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Alcohol and Drug Research Newsletter

Dáil debate on cannabis

See pages 6–9.

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National Drugs Strategy Conference

On 16 January 2014 the Department of Health hosted a half-day conference for those in the government, statutory, community and voluntary sectors working in the drugs and alcohol field. Tánaiste Eamon Gilmore TD (pictured) and Minister of State Alex White TD addressed the conference. They were followed by Fergus McCabe of CityWide Drugs Crisis Campaign and Tony Duffin of Ana Liffey Drug Project (ALDP), representing the community and voluntary sectors.

Reaffirming the primacy of the National Drugs Strategy and the five 'pillars', Tánaiste Gilmore stressed the importance of maintaining the partnership approach in face of emerging challenges, including prescription drugs and grow houses. Minister White outlined the extensive review of the drugs task forces and the series of bilateral meetings with other government ministers, state agencies and the community and voluntary sectors on drugs and alcohol issues, which had just concluded. Susan Scally of the Drug Policy Unit in the Department of Health described the outcomes of the review and the bilaterals and this information is covered in the article 'Supporting local efforts to tackle the drug problem' on p.4 of this issue.

Speaking on behalf of the community sector and reflecting on the last twenty or so years of drug policy implementation in Ireland, Fergus McCabe listed five things necessary to ensure effective policy implementation:

- political commitment with a special focus on disadvantage,
- effective cross-cutting and co-ordinating structures,
- equitable distribution of adequate resources,
- timely and relevant research and evaluation, and
- processes for real engagement involving all sectors.

Continued on p. 3

Health Research Board welcomes new CEO

Dr Graham Love took over as chief executive of the Health Research Board (HRB) at the end of March. He replaces Enda Connolly, who retired on 31 January 2014 after more than five years in the position.

Graham will bring 15 years' leadership and senior management experience to the HRB, his most recent role being that of chief executive of Molecular Medicine Ireland. He previously held a number of senior positions at Science Foundation Ireland, where he was responsible for the development of SFI's 2009–2013 strategy, *Powering the Smart Economy*, a €1.1 billion plan to drive delivery of the government's enterprise science agenda, and its successor, *Agenda 2020*.

Graham was chief executive of Multiple Sclerosis Ireland between 2005 and 2006. Before that he spent almost a decade with management consulting firm Accenture. He graduated from University College Dublin with a BSc in Pharmacology in 1993, followed by a PhD in vascular cell biology in 1997.

Contents

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National Drugs Strategy Conference *(continued)*

At the NDS conference: Gary Broderick, director Saol Project; Mel MacGiobúin, co-ordinator North Inner City Drugs Task Force; and Fergus McCabe, CityWide Drugs Crisis Campaign

Tony Duffin of ALDP spoke on behalf of the National Voluntary Drug Sector (NVDS), a representative body of voluntary drug services across the state which engages with the drugs task force structures and processes. The NVDS has identified four key issues regarding the implementation of the National Drugs Strategy:

- *Lack of a national representative body to oversee implementation:* in principle, the newly established National Co-ordinating Committee will meet this need but to be effective it must be a real decision-making forum.
- *Role of drugs task forces needs to be refocused and reconstituted:* the recent review addresses this need and a timeframe for implementing the recommendations needs to be put in place. Speaking from his own experience in ALDP, Duffin stressed the need for task forces to take an evidence-based approach to selecting services
- *Alcohol:* what existing budget is there for alcohol and what budget will be transferred for the implementation of the combined drug and alcohol strategy? Duffin pointed out that the health costs of alcohol use far exceed tax receipts from the drinks industry. Also, what role is envisaged for the voluntary sector with regard to alcohol? Duffin pointed out that merging drug and alcohol policies will mean treatment options, including residential services, will have to be enhanced to ensure polydrug users are not excluded.
- *Funding:* the cuts since 2008 have resulted in services being cut and this has had a real impact on service users. At ALDP much of the progress made over the last 15 years is being lost and the service is 'moving backwards'.

After coffee the conference heard four presentations on incorporating alcohol in prevention work.

Promoting community engagement in addressing alcohol issues

Community action seeks to change collective rather than individual behaviour. Because it impacts on the environment, it is a universal approach. Mobilising a community to action on alcohol effectively anchors and maximises the work by actively involving local groups and exploiting existing networks. Anne Timoney of Community Action on Alcohol outlined the process, from introducing the concept to developing the action plan, implementing and evaluating. www.alcoholforum.org

Ballymun community alcohol strategy

Titled *A road to change: Ballymun Community Alcohol Strategy 2010–2016*, the strategy aims to use a public health approach to reduce alcohol-related risk to the Ballymun community's health, safety and well-being. Hugh Greaves, co-ordinator of the Ballymun LDTF, outlined the process whereby the strategy was developed, the principles underpinning the approach, and the contents – 41 actions across six pillars:

1. Supply reduction, availability and enforcement
2. Community awareness
3. Treatment and rehabilitation
4. Prevention and education
5. Harm reduction
6. Policy and research

www.ballymunlocaldrugstaskforce.ie/communityalcoholstrategy

Galway City alcohol strategy

The Galway City strategy to prevent and reduce alcohol-related harm 2013–2017 focuses on four key areas – prevention; supply, access and availability; screening, treatment and support services; and research, monitoring and evaluation – and includes 40 associated actions. An annual action plan is developed, including commitments from a range of partners, groups and organisations for each proposed action, and, at the end of the year, a progress report is compiled. Among the achievements to date, Evelyn Fanning of HSE West highlighted increased public awareness of the issues, improved information and understanding of alcohol availability and advertising, and patterns of alcohol-related harm, and responses that have begun to have an effect on the level of alcohol-related problems. www.galwayalcoholstrategy.ie

Hello Sunday Morning (HSM) initiative

HSM is a blogging website that encourages people to undertake a period of sobriety and reflect on the role alcohol plays in their life. Bloggers or 'HSMers' come from several countries but are predominantly Australians. They write blog posts, make videos and take pictures of their experiences as part of their participation. Ian Power of Spunout.ie described a study that aimed to conceptualise and evaluate the social impact of HSM. Analysis of the blog posts of 1,768 HSMers showed that over time they changed from being very self-focused, considering their own drinking and the views of peers, to reflecting on the role of alcohol in their lives, to finally taking a broader view of the role of alcohol in society and ways to help and support others in their personal HSM experiences. www.hellosundaymorning.org

Supporting local efforts to tackle drug problems

On 23 January 2014 the new National Co-ordinating Committee for Drug and Alcohol Task Forces (NCC) held its inaugural meeting. Its purpose is to guide the work of the task forces and drive implementation of the National Drugs Strategy 2009–2016 (NDS) locally. It is the successor to the Drugs Advisory Group, established under the NDS,[1] and to the National Drugs Strategy Team, which was incorporated in the 2001–2008 national drugs strategy.[2]

The following account is based on a presentation given by Susan Scally, head of the Drugs Policy Unit in the Department of Health, at the half-day conference on Ireland's National Drugs Strategy (NDS), which is described elsewhere in this issue of *Drugnet Ireland*.[3]

Terms of reference for the NCC

- drive implementation of the NDS at local and regional level,
- oversee, monitor and support the work of the task forces and to ensure that policy on drugs is informed by their work,
- monitor implementation of NDS actions specific to drug and alcohol task forces,
- monitor the expenditure and activities of the task forces and of drugs projects in their areas, and
- make recommendations to the minister in relation to the implementation of the NDS and effective co-ordination of service delivery at local and regional level.

Membership of the NCC

- *Statutory sector*: Department of Health, HSE, An Garda Síochána, Justice, Equality and Defence, Revenue Customs Service, Children and Youth Affairs, Education and Skills, Environment, Social Protection, Community and Local Government, Local Government Management Agency, Probation Service, Education and Training Boards
- *Community sector*: two representatives
- *Voluntary sector*: two representatives
- *LDTF Chairs Network*: two representatives
- *LDTF Co-ordinators Network*: two representatives
- *RDTF Chairs Network*: two representatives
- *RDTF Co-ordinators Network*: two representatives

Role of NCC in supporting local efforts to tackle the drug problem

- brings together local and regional drugs task forces, key government departments and agencies and the community and voluntary sector,
- roles and responsibilities of members clearly set out to encourage optimum participation,
- strengthened accountability and feedback mechanisms,
- opportunities for sharing best practice, and
- more outcomes focused.

New terms of reference for task forces

- implement the NDS in the context of the needs of the region/local area,
- support and strengthen community-based responses to drug misuse,
- maintain an up-to-date overview on the nature and extent of drug misuse in the area/region,
- identify and report on emerging issues and the development of proposals on policies or actions needed to address them,
- promote the implementation of local/regional drug strategies, and
- monitor, evaluate and assess the impact of the funded projects and their continued relevance to the local/regional drugs task force strategy and to recommend changes to the funding allocations as deemed necessary.

NCC support for task forces in change process will include

- adoption of their new terms of reference,
- criteria for membership and tenure of members,
- measures to strengthen governance and decision making,
- monitoring and reporting arrangements, and
- supporting local services to achieve quality standards in the delivery of services.

Minister's bilateral meetings

According to Susan Scally, the above changes were the outcome of a review of drugs task forces and national structures decision completed in 2012,[4] and a subsequent series of bilateral meetings between Minister of State White with his counterparts in other government departments, with statutory agencies, and with representatives of the community and voluntary sectors and the regional and local drugs task forces. Ms Scally listed the key strategic issues to emerge from these bilateral meetings as follows:

Supply reduction

- Garda and Revenue Customs Service joint operations result in significant seizures of drugs.
- Significant seizures of new psychoactive substances by Customs; shift to internet outlets is an emerging challenge.
- Drug-related Intimidation Reporting Programme is an ongoing partnership between gardaí, Family Support Network and HSE.
- An inspector in every Garda division is to target adults in the drug trade who use children to run drugs.

Education and prevention

- 90.2% of children sit Leaving Certificate, which is regarded as a protective factor.
- Outcomes-focused Children and Youth Strategy Framework is in final stages of development.

Supporting local efforts *(continued)*

- 30% of children live with parental alcohol substance misuse.
- Supports for children and young people at risk in high-support settings (assessment, consultation and therapy service) – HSE, Irish Youth Justice Service.

Treatment

- Nationwide access to treatment services:
  - Almost 100% of over-18s access treatment within one month;
  - Almost 100% of under-18s access treatment within one week.
- Probation Service works with prison, gardaí and treatment services to intervene with clients with substance misuse problems.
- Three main health issues affecting prisoners are mental health, poor physical health and drug addiction.
- Expansion of drug treatment (including methadone treatment) and other health and social services in prisons and in-reach services as required.
- Protocol in place for seamless provision of treatment services between prison and the community.
- Drug treatment in prisons contributing to a reduction in the incidence of post-release overdoses.

Rehabilitation

- Very positive feedback from National Drug Rehabilitation Implementation Committee (NDRIC) evaluation; drugs task forces played a key role.
- National roll-out of NDRIC is planned.
- Issue with take-up of places on drug-specific Community Employment (CE) schemes; an advisory committee under aegis of Department of Social Protection is examining the model.

1. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs, paragraph 6.50. www.drugsandalcohol.ie/12388/
2. Department of Tourism, Sport and Recreation (2001) *Building on Experience: National Drugs Strategy 2001–2008*. Dublin: Stationery Office, Dublin, paragraphs 3.6.4–3.6.5 and Actions 85–91. www.drugsandalcohol.ie/5187/
3. Susan Scally's presentation is available at www.drugs.ie/multimedia
4. Department of Health (2012) *Report on the review of drugs task forces and the national structures under which they operate*. Dublin: Department of Health. www.drugsandalcohol.ie/19054/

Drug strategy to be evaluated

In December 2013 the Home Office published an evaluation framework,[1] developed to assess the effectiveness and value for money (VFM) of the English and Welsh Drug Strategy 2010, which expires in 2015.[2]

Reason for the evaluation

While noting that data are available to monitor trends in drug use and also the numbers leaving drug treatment drug free, the evaluation framework document argues, '… it is not sufficient only to consider changes in these data as this does not enable us to attribute changes, whether they be good or bad, to the effects of the Strategy (i.e. we would not be able to prove that it was the Strategy that caused any changes in drug use or recovery)' (p.8). The document goes on to state that, in order to robustly assess the effectiveness of the drug strategy in meeting its aims, it is necessary to evaluate the impacts of the programmes and interventions being undertaken as part of the strategy.

The scope of the evaluation

The Home Office states that the evaluation must be capable of assessing whether the drug strategy has met the overarching objectives and aims contained in the strategy document. While these are non-quantitative and aspirational, the Home Office argues that value for money will have been achieved if the money spent on tackling drug use is less than the monetised benefits resulting from the drug strategy (see accompanying figure).

How will the evaluation be undertaken?

The framework document outlines the steps in the evaluation, some of which have already been completed.

Source: HM Government (2013) *Drug strategy 2010 evaluation framework*, p.8

1. Drug-related programmes and interventions have been divided into five activity groups, each of which links to one or more of the objectives and aims set out in the 2010 drug strategy and where common aims and measurement can be applied. The five groups are early interventions, education and information approaches, treatment, non-treatment rehabilitative activity, and enforcement. A 'logic model' has been developed for each of these activity groups, outlining how they should operate to achieve their aim.[3]
2. A meta-evaluation approach[4] will be used to combine the results from different evaluations within each activity group. Where sufficient evidence is available, separate VFM estimates will then be calculated for the five activity groups. The Home Office acknowledges that there are considerable gaps in evidence, and states that one of the intentions of the evaluation is to stimulate debate about how to fill these gaps.

Drug strategy to be evaluated *(continued)*

3. Having gathered data and estimated direct government spend on tackling drug use for each of the five activity groups, the direct return on investment (RoI) will then be assessed. This will be more difficult for some interventions than for others. For example, it has long been problematic to identify the drug-related proportion of enforcement spend (such as police activity), and of the spend for interventions which are not specifically aimed at drug users, such as early interventions. The evaluation framework document discusses how it proposes to tackle these challenges in some detail.
4. Both drug-specific benefits and wider benefits relating to health, crime and employment will be identified with the help of the logic models. The scale of these benefits, and the extent to which they were caused by *Drug Strategy 2010*, will then be evaluated. Evaluating benefits will be made more complex in certain areas, such as the non-treatment rehabilitative activity group, due to the outcomes and benefits of one intervention likely overlapping with the outcomes of another. Any overlap will need to be recognised and benefits shared appropriately across the activity groups.

The evaluation of national drug strategies has been the subject of considerable debate across Europe and the international drug policy community.[5] In the introduction to this evaluation framework document, the Home Office stresses that evaluating the drug strategy is a work in progress, a learning experience, which is likely to evolve as new information and evidence emerge.

(Brigid Pike)

1. HM Government (2013) *Drug strategy 2010 evaluation framework – evaluating costs and benefits*. London: Home Office. www.gov.uk/government/uploads/system/uploads/attachment_data/file/265393/Drug_Strategy_Evaluation_Framework_FINAL_pdf.pdf. This document defines VFM as 'the societal return on investment at a national level' (p.8).
2. HM Government (2010) *Drug strategy 2010 reducing demand, restricting supply, building recovery: supporting people to live a drug free life*. London: Home Office. https://www.gov.uk/government/publications/drug-strategy-2010--2
3. According to the D*rug strategy 2010 evaluation framework*, 'Logic models describe the theory, assumptions and evidence underlying the rationale for a policy, by linking the intended outcomes (both short and long-term) with the policy inputs, activities, processes and theoretical assumptions' (p.12).
4. According to the *Drug strategy 2010 evaluation framework*, meta-evaluation is 'the synthesis of results from individual evaluations falling within the same activity group (e.g. enforcement), to provide an overall estimate' (p.11).
5. See Pike B (2010) Evaluating national drugs strategies. *Drugnet Ireland*, (34): 12–13. www.drugsandalcohol.ie/13295/

Dáil debate on cannabis

For the first time since 2006, Irish politicians have had a full debate on the drugs issue, specifically on a private member's motion to regulate the cultivation, sale and possession of cannabis and cannabis products.[1] They voted 112 to 8 in favour of a government amendment that recognised the health risks associated with cannabis and its role as a 'gateway' drug, recognised that leniency in cannabis control could endanger overall international efforts against drugs, to which Ireland is signed up under the 1961 and 1971 UN drug conventions, and endorsed current government policy 'to maintain strict legal controls on cannabis and cannabis products in Ireland'.

In the next section what politicians said is described, and in the following two sections, recent research, analysis and commentary relevant to the processes of drug policy debate are discussed.

(1) What did the politicians say?

Individual deputies contributing to the debate raised three different options – prohibition, decriminalisation or regulation.[2] The arguments made in favour of the various options were as follows:

Prohibition

- The current system of strict controls and regulation of cannabis should continue because of the health and social risks associated with cannabis use.
- Cannabis is a 'gateway' drug.
- The balance of the greater good for society lies in continuing prohibition.
- The current economic situation would preclude putting in place the measures to deal with the 'excesses' that would ensue if cannabis were legalised.
- The benefits of legalisation would not exceed the costs.
- Ireland would become an even bigger channel for the importation of illegal drugs to Europe.
- Why reduce controls on drugs when controls on tobacco and alcohol are being strengthened?

Decriminalisation

- Need to stop using prison as a means to tackle the drug issue. Most drug users do not commit crimes except the crime of possession.
- Users found with small amounts of cannabis should not be criminalised or jailed, should not have convictions.
- In Portugal decriminalisation has led to a reduction in drug-related deaths, with no increase in drug prevalence.
- Decriminalising cannabis is a minimum step and a first step along the road in this debate.
- If cannabis were to be legalised, there is as yet no assurance that the drug gangs will be tackled or that enough treatment centres, mental health services and other supports needed will be provided.

Regulation

Given that cannabis is freely available in Ireland and its use is normalised (over 7% of the population regularly use cannabis), the situation should be regulated so that cannabis users are not criminalised and criminals do not profit from the market in cannabis.

- Public opinion supports regulation of the cannabis market.
- The health risks have not been conclusively proven.
- Regulation of recreational and medicinal cannabis use is happening elsewhere in the world.

Dáil debate on cannabis *(continued)*

(2) What could the politicians have said?

The Dáil record of the recent debate on cannabis regulation indicates that while deputies acknowledge the importance of ensuring their policy arguments are consistent with scientific evidence, there is a need for more systematic and careful reading of the evidence, and more rigorous analysis of the policy options.

Reading the evidence

In referring to the scientific evidence, deputies both for and against the cannabis regulation motion tended to cite single, isolated items of research that supported their perception of the risks associated with using cannabis, particularly health-related risks such as dependence, respiratory problems, lung and throat cancers, heart disease, strokes, epilepsy, a range of mental illnesses, impaired development in young people, and reduced fertility. Regarding the whole body of scientific evidence, four US public policy academics have argued in a recent publication:[3] 'The hard truth is that the scientific community has not reached a consensus on many of these questions so both sides of the legalization debate can refer to published studies that support their arguments and claim that the other side is ignoring the science. **But the uncertainties are important**.' (pp.54–55; emphasis added.)

The authors identify two critical uncertainties:

- *Marijuana is not a standardised commodity*: The level of THC and other cannabinoids in the marijuana used by research subjects will vary and may influence the outcomes of interest; moreover, the amount of marijuana consumed by research subjects and over what time period will also vary, making it difficult to make comparisons across studies.
- *Causality as distinct from correlation*: In many studies, it has proved difficult to determine conclusively whether marijuana caused the negative consequences or just happened to be correlated with them.

Marijuana's status as a 'gateway drug' is given as an example of 'uncertainty' with regard to causality. While young people who use marijuana, especially when they start at a young age, are statistically more likely to go on to use other drugs than their peers who do not use, the authors ask whether this means that marijuana *causes* the subsequent drug use or does it simply *signal* the risk of subsequent drug use, owing to other factors such as underlying social, psychological or even physiological factors. In a further twist of uncertainty, the authors also point out that because a causal connection is not needed to explain the observed correlation does not mean that there is no causal connection.

In citing scientific evidence, the authors also advise that the validity and reliability of the research must be assured. Was the research design sound? Was the sample size large enough and the timespan of the study long enough to ensure reliable findings? Were appropriate analytical tools applied to the data?

Analysing the options

Expressing their personal preferences in the Dáil debate – for prohibition, decriminalisation or regulation – deputies generally justified their choice by pointing to risks that need to be avoided or to changing circumstances that need to be responded to. They tended not to explain their preference in terms of a policy framework or an overall rationale. In recent years, drug policy researchers have proposed a range of such frameworks and rationales, for example maximising the public good, treating the drugs issue as a governance rather than a criminal issue, or addressing the drugs issue as part of equality policy.[4] The advantages of such frameworks are that they shift the debate away from the polarised and increasingly unproductive debate between prohibition on the one hand and legalisation/regulation on the other, and they also introduce an analytical rigour, which arguably leads to greater transparency and accountability.

To give an example of how an explicit policy framework can enhance the calibre of the policy debate by making explicit the logical underpinning: In the course of the Dáil debate, a number of deputies who were opposed to changing the law on cannabis raised a conundrum, why relax controls on illicit drugs when simultaneously strengthening controls on licit substances such as tobacco and alcohol? One possible answer has been provided by proponents of a public health and human rights-based policy framework as a basis for thinking about cannabis.[5] Alcohol, tobacco and cannabis have all been available in unregulated markets, be they legal or illegal markets, with little regard to public health or human rights: to strengthen public health and human rights outcomes, all three markets should be strictly regulated by law (see graphic).

Source: TDPF (2013) *How to regulate cannabis: a practical guide*, p.26.

What the 'experts' said

To underline the uncertainty and complexity of the issues around marijuana, the four US public policy experts whose work is discussed above took the unusual step of each writing their own conclusion to their joint book on the pros and cons of legalising marijuna.[3] They all favoured a shift away from complete prohibition but varied in how far they would relax controls and how fast.

Hawken: 'Given already widespread use among adults and kids, the enormous costs of marijuana prohibition, and the inconsistencies in our drug laws, it seems worthwhile to experiment with legalization in the United States. … [Having allowed for experimentation with different legal regimes at state level, and having adjusted taxes and controls on alcohol and tobacco markets] I would then support removing the federal ban on marijuana, and managing marijuana with regulations similar to those that apply to alcohol. This would mean strict licensing rules for production and sales, controls on advertising and product labelling, penalties for negative behaviours following use, and taxes high enough to avoid spikes in use.' (p.236)

Dáil debate on cannabis *(continued)*

Caulkins: 'I would vote against legalizing marijuana. Most of what people dislike about the current prohibition can be fixed by reforming prohibition and/or pursuing "middle path" options. Among middle path options, decriminalisation plus home growing and sharing (with or without user co-ops but without commercial production and sale) strikes me as having particular advantages for shrinking the black market.' (p.238)

Kleiman: 'My first choice [among (1) prohibition, (2) decriminalisation, (3) permission to grow, (4) legalisation without commercialisation, (5) controlled commercialisation, and (6) lightly controlled commercialisation] is permission for production and use through small not-for-profit cooperatives, with a ban on commerce [i.e. option 4].' (pp.243–4)

Kilmer: 'Whatever you do, incorporate a sunset provision. …Given the weak knowledge base, it is risky to implement the most extreme alternative to prohibition. …Incremental approaches that experiment with different combinations of activities relating to marijuana [i.e. (1) possession of small amounts, (2) non-profit production and sharing in private homes or small co-operatives, (3) retail sales, (4) commercial and/or government production, and (5) advertising and promotion] are inherently less risky than implementing them all at the same time.' (pp.246–7)

(3) Are politicians part of the problem or the solution?

The two previous sections of this report on the recent Dáil debate on cannabis regulation discussed what was said in the debate, and how the deputies might have raised the calibre of their contributions. In this final section, recent research into how politicians can influence the development of drug policy is described. Several themes have emerged from this research:

- *Drug policy goals* may be clearly enunciated but are they an accurate statement of what politicians really intend? Do all people, groups, agencies share a common view of the benefits and the harms associated with a specific drug policy? It is suggested that the motives of the 'political élites' that control the policy process are obscure, making it difficult to accurately assess whether their policies are succeeding or failing.[6]
- *Concepts* used to debate the drugs issue may not change over long periods but what is meant by the conceptual terms may well change. They are 'political tools' which can be manipulated to respond to changing moral climates and circumstances. The entrance of new actors into the policy debate, for example not only politicians but also experts, administrators and drug users, will influence the negotiation and agreement of shared conceptual understandings.[7]
- *Language* is the basis on which policy problems are constructed and represented. The resulting 'discursive constructions' have implications for how policy responses are understood and justified. By changing the language of policy, politicians can reframe the 'problem'; for example, shifting from talking about drug use to drug harms, or away from talking about *abuse* or *misuse* can alter the impact of a drug policy.[8]
- *Grand narratives*, comprising story lines and symbolic devices, are used by politicians to paint a picture of just what the 'drug problem' is at any particular time. The choice of issues is framed by a heady mix of evidence, moral and ethical values, ideologies, mass media coverage, public opinion and political opportunism. To achieve a more rational approach, in which evidence and logic prevail, 'exceptional leadership' is required and the drugs issue needs to be positioned in a broader policy context such as health, inequality or poverty.[9]
- *Political games* The drug issue tends to be used as a weapon in political games, e.g. shoring up one's own ideological position while undermining that of an opponent, and in electioneering. In such a political climate, scientific evidence and calm appraisal lose out, or are distorted by underpinning values and political interests.[10]

Only twice have Irish politicians taken the wheel in formulating Ireland's drug policy, in 1983/4 and 1996/7.[11] On both occasions, the Ministers of State tasked with developing government policy delivered the boldest, most radical and most innovative policy proposals in the history of Irish drug policy. Government strategies produced at other times, by teams of either 'experts' or government officials, have tended to be more conservative, consolidating existing policy positions, 'building on experience'. Perhaps in 2016, when the current *National Drugs Strategy* expires and the task of drafting a combined drug and alcohol strategy arises, when the UN General Assembly holds its first Special Session (UNGASS) on drugs since 1998, and 20 years after the last ministerial task force on drugs was convened, it will be time for Irish politicians once again to take a turn at the wheel.

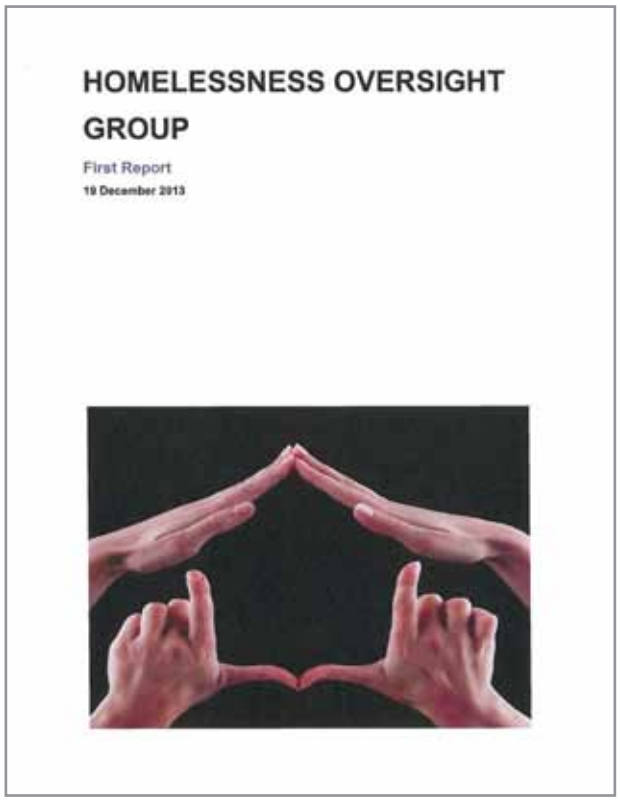
(Brigid Pike)

1. Cannabis regulation: motion [Private Members] (2013, 5–6 November) *Parliamentary Debates Dáil Éireann (Official Report—Unrevised)*, Vol. 819/1, pp.91–111 & Vol. 819/2, pp.846–869.
2. For a discussion of previous Dáil debates on the drugs issue, see Pike B (2012) Politicians and the drugs debate – six years on. *Drugnet Ireland*, (41): 10. www.drugsandalcohol.ie/17272/, and Pike B (2006) Politicians and the drugs debate. *Drugnet Ireland*, (19): 16–17. www.drugsandalcohol.ie/11285/.
3. Caulkins JP, Hawken A, Kilmer B and Kleiman MAR (2012) *Marijuana legalization*: *what everyone needs to know*. New York: Oxford University Press.
4. For a brief outline of these frameworks, see Pike B (2012) To prohibit or not to prohibit – that is no longer the question. *Drugnet Ireland*, (41): 7–8.
5. Transform Drug Policy Foundation (TDPF) (2013) *How to regulate cannabis*: *a practical guide*. London: TDPF. The authors set out a policy framework comprised of six broad aims: protecting and improving public health, reducing drug-related crime, improving security and development, protecting the young and vulnerable, protecting human rights, and providing good value for money.
6. Friedman SR, Mateu-Gelabert P and Rossi D (2012) Has United States drug policy failed? And how could we know? *Substance Use and Misuse*, 47(13–14): 1402–1405.
7. Edman J and Stenius K (2013) Conceptual carpentry as problem handling: the case of drugs and coercive treatment in social democratic welfare regimes. I*nternational Journal of Drug Policy*, http://dx.doi.org/10.1016/j.drugpo.2013.10.005; Houborg E (2012) The political pharmacology of methadone and heroin in Danish drug policy. *Contemporary Drug Problems*, 39(1): 155–192.
8. Lancaster K and Ritter A (2014) Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985–2010. *International Journal of Drug Policy*, 25(1): 81–87.

Dáil debate on cannabis *(continued)*

9. MacGregor S (2013) Barriers to the influence of evidence on policy: are politicians the problem? *Drugs: education, prevention and policy*, 20(3): 225–233.
10. Edman J (2013) An ambiguous monolith – the Swedish drug issue as a political battleground 1965–1981. *International Journal of Drug Policy*, 24(5): 464–470; Tieberghien J and Decorte T (2013) Understanding the science–policy nexus in Belgium: an analysis of the drug policy debate (1996–2003). *Drugs: education, prevention and policy*, 20(3): 241–248.
11. For detailed accounts of Ireland's drug policy since the 1960s, see Butler S (2001) *Alcohol, drugs and health promotion in modern Ireland*. Dublin: Institute of Public Administration, and Pike B (2008) *Development of Ireland's drug strategy 2000–2007*. HRB Overview Series 8. Dublin: Health Research Board. www.drugsandalcohol.ie/11465.

Homelessness Oversight Group submits its first report



The first report of the Homelessness Oversight Group was recently released.[1] The Group was established by the Minister for Housing, Jan O'Sullivan TD, in February 2013. Its role, as set out in the policy statement on homelessness launched by the minister on the same day, was to monitor and review progress on the housing-led approach to end long-term homelessness and need to sleep rough by the end of 2016.[2] This first report, based on consultations with representatives from 36 stakeholders, a review of Pathway Accommodation and Support System (PASS) data on homelessness in the period ending September 2013, and detailed consideration of relevant policy-related material, gives a realistic account of the major obstacles to achieving the 2016 goals and a detailed set of recommendations on how these obstacles can be overcome.

Trends in homelessness

The Group acknowledges that changes to the methods of measuring homelessness over the last 10 years means it is difficult to track precisely what progress has been made in reducing either overall homelessness or long-term homelessness. However, they suggest that the indicators available point to progress being slow. In reviewing the available datasets, including the *Counted in, 2008* estimates and Census 2011 and the PASS data, the authors signal that overall 'it seems likely that no significant reduction in long-term homelessness had occurred between 2008 and 2011. Rough sleepers are on an upward trend… [and] … little change in the incidence of homelessness seems to have occurred in Dublin in recent years' (pp.9–10).

Obstacles to progress to securing permanent housing

The housing-led approach seeks to place homeless people in sustainable rented accommodation as a first step, and provides 'floating supports' at the request of the person being housed. Such supports may include assistance with social welfare enquiries, developing independent living skills or seeking help for addiction problems. The Group's report is quite explicit in identifying the key obstacle to this approach as a structural one, centred on the lack of integration between two social policy and implementation areas – care and housing. This lack of integration is neatly encapsulated in the following extract from the report:

> …housing providers [i.e. local authorities, approved NGOs and the Department of Social Protection] have housing responsibilities which go well beyond the homeless and embrace a wide range of low-income households. … Their priority targets (such as families with children and elderly households) do not include the single adult males who make up the majority of the long-term homeless. Homeless agencies, by contrast, are more narrowly focused on provision of shelter, social supports and related health services to the homeless but also require access to long-term housing in order to meet what is *the* core need of their clientele – the need for a permanent home. … they depend on housing providers since they themselves have little role in housing but they struggle to make successful claims for access in the light of the low priority accorded to their clientele in the wider system of housing allocations. (p.10)

Recommendations to overcome blockages

The report's core recommendation is that a high-level team be set up and given responsibility for achieving the 2016 objectives This Homelessness Policy Implementation Team would be part of the general housing policy section of the Department of the Environment, and supported by an implementation unit. It is proposed that the team would enter into service level agreements (SLAs) with approved housing bodies capable of accessing capital funding from the Housing Finance Agency to supply permanent housing units, and with agencies providing care and support for the homeless people when they are housed.

Homelessness group reports *(continued)*

Are the 2016 objectives attainable?
The Group sets out four grounds on which the 2016 objectives can be realised:

- The scale of homelessness is not insurmountable: an estimated 1,500–2,000 permanent housing units being made available over the next three years is not an unrealistic target given that the state currently provides an estimated 250,000 state-supported housing units.
- There are many under-used housing units and related financial resources which could be used to tackle and reduce long-term homelessness.
- Current expenditure on expensive short-term accommodation and shelter will be freed-up as the long-term homeless make the transition to permanent housing.
- Services provided to meet the health and social care needs of homeless people have improved greatly since the early 2000s, providing a platform on which to build an infrastructure of care and support to sustain long-term tenancies when the supply of permanent housing is increased.

Recent research[3] found that the views of stakeholders in Ireland were in broad agreement with the international consensus that responses to homelessness involve more than just providing housing in the form of 'bricks and mortar'. Effective responses need to include housing alongside appropriate support, especially for people with high-support needs. The present report concurs with these findings, stating: 'As the long-term homeless are moved into permanent housing between now and 2016…services will need to follow them and provide necessary supports in new ways and in new contexts' (p.4).

(Martin Keane)

1. Kennedy M, Langford S and Fahey T (2013) *Homelessness oversight group (First report) 2013*. Dublin: Dublin Region Homeless Executive. www.drugsandalcohol.ie/21105
2. Department of the Environment, Community and Local Government (2013) *Homelessness policy statement*. Dublin: Department of the Environment, Community and Local Government. www.drugsandalcohol.ie/19346
3. Pleace N and Bretherton J (2013) *Finding the way home: housing-led responses and the homelessness strategy in Ireland*. Dublin: Simon Communities of Ireland. www.drugsandalcohol.ie/20183

Drug policy advocacy organisations in Europe

In December 2013 the EMCDDA published *Drug policy advocacy organisations in Europe*.[1] Presenting the results of a mapping study of such bodies undertaken by Aileen O'Gorman of UCD, this paper describes how civil society organisations engaging in drug policy advocacy in Europe are today well organised, high-profile and impact-oriented. Their development has been driven by greater ease of communication (facilitated by new technologies) and the greater number of formal mechanisms through which policymakers can now be reached.

Advocacy is defined in the paper as '…activities and actions with the intention of influencing decision-makers and with the aim of developing, establishing or changing policies and practices and of establishing and sustaining programmes and services'.[2] Three main categories of drug advocacy, all perceived to be following a transformative strategy for achieving social justice, are described in the paper (p.4):

- self or peer advocacy undertaken by individuals and peer groups speaking out for themselves, and often associated with the rights-based agendas of disability and mental health activism;
- professional advocacy undertaken by 'helping professions' speaking on behalf of a person or an issue, often seeking the removal of structural barriers hindering their constituency's needs being met; and
- public policy advocacy seeking to effect change mainly through legislation and resource allocation.

An additional distinction is drawn between *case* and *cause* advocacy, with case advocacy focusing on the needs of the individual and cause advocacy addressing social reform. Advocacy is also observed to intersect the realms of lobbying, interest groups and social movements, in terms of their shared aims of influencing public policy and resource allocation decisions, legislation, or both, though by different approaches.

Drug advocacy organisations are defined in the paper as bodies with a website-based internet presence that contains a clearly stated aim to influence drug policy. Of the 218 organisations identified across 30 countries, 69% operated on a national basis, around one-fifth (17%) had a local or regional remit and over one-tenth (14 %) had a European or international remit. The primary objectives of the organisations were found to be predominantly in the area of practice development and delivery (65%), with 26% advocating use reduction and 39% harm reduction approaches. Primary objectives in the field of legislative changes were pursued by the remainder, with 23% in favour of control reduction and 12% calling for control reinforcement.

The organisations included in the study, including 11 in Ireland (see box), were found to be engaged in targeted activities, aimed at influencing the attitudes and opinions of the public and policymakers on drug service provision, drug controls, or both. These activities are grounded in aspirations for an improvement in the well-being of the individuals, groups or societies affected by drug use. The paper concludes that changes in the nature, methods and impact of advocacy in the drugs area are evolving against a backdrop of economic crisis. As drug services and law enforcement agencies come under increased financial pressure, it is considered likely that the number and type of policy actors engaged in advocacy will grow. Equally, as communities affected by drug problems experience renewed difficulties in providing services, an increased impetus to engage in advocacy may emerge.

Drug policy advocacy organisations in Europe *(continued)*

Drug policy advocacy organisations in Ireland

Ana Liffey Drug Project

Ballymun Youth Action Project

CityWide Drugs Crisis Campaign

Family Support Network

ICON (Inner City Organisations Network)

INEF (Irish Needle Exchange Forum)

Irish Penal Reform Trust

Jesuit Centre for Faith and Justice

Merchants Quay Ireland

SAOL Project

UISCE (Union for Improved Services, Communication and Education)

Drug policy advocacy organisations in Europe is one of four studies published by the EMCDDA in its new series, 'EMCDDA Papers'. Primarily targeting policymakers and specialists, the papers are designed as brief and timely web-based products on a variety of topics in the drugs field. To be published several times a year, the papers will cover all aspects of Europe's drug phenomenon, from consumption and markets to health and social consequences as well as the responses of the EU and its member states to drug problems.

1. European Monitoring Centre for Drugs and Drug Addiction (2013) *Drug policy advocacy organisations in Europe*. EMCDDA Papers. Luxembourg: Publications Office of the European Union. www.drugsandalcohol.ie/21063
2. This definition was developed by the Vienna NGO Committee on Narcotic Drugs. This committee links non-governmental organisations (NGOs) with UN intergovernmental and international agencies involved in drug policy, strategy and control: the Commission on Narcotic Drugs (CND), the International Narcotics Control Board (INCB) and the United Nations Office on Drugs and Crime (UNODC). www.vngoc.org

European research on risk factors for overdose

Opiates (both illicit and prescribed) continue to be a significant factor in many poisoning deaths, not only in this country (see article on p. 14) but also internationally. In international literature, poisonings are also known as drug-induced deaths or overdose. Some of the key findings about opiate overdose in Europe are shown in the box below.

- There are 1.4 million problem opiate users in Europe.
- There were 6,500 overdose deaths in 2011.
- There were more than 70,000 overdose deaths during the first decade of the 21st century.
- Overdose deaths represent 4% of all deaths in adult males aged under 40.
- Half of all deaths in people who regularly inject heroin are attributable to overdose.
- On average, heroin users who overdose report having experienced three overdoses.
- Many heroin users who survived an overdose did not perceive themselves to be at high risk of overdose, even though they had a history of overdose in the previous six months.

Sources: EMCDDA (2013)[1] and Frisher *et al.* (2012)[2]

Several recent publications have looked at the risk factors for overdose and strategies for prevention.[1,2,3]

Risk factors

There are many, often inter-related, risk factors for fatal and non-fatal overdose. Recognition of these factors can help prevent the occurrence of overdose. Availability of opiates, route of administration, polydrug use, periods of abstinence and health of the user are some of the common factors.[2,3]

Based on a comprehensive review of the literature, Frischer *et al.* (2012) identified and classified risk factors at three levels: individual, observers and organisational. The table below lists the individual risk factors. Observer risk factors relate to the perceived consequences of becoming involved, e.g. risk of arrest if police are called. Organisational risk factors relate to the availability and flexibility of the treatment, response to treatment and misuse of prescription drugs. Another resource in this area is the ORION Project.[4] This is an ehealth tool for assessing overdose risks factors and is available for download from http://orion-euproject.com.

The literature points to several main areas for prevention, both to reduce the risk of an overdose occurring and to prevent fatality in the event of an overdose.

Overdose prevention information and training

The literature shows that problem opiate users often underestimate their risk of overdose[1] so information, counselling and training to recognise the risks for, and signs of, overdose is vital. This information, along with training in basic cardio-pulmonary resuscitation, should also be provided to family and friends.

Treatment

Access to, and retention in, treatment, including opiate substitution treatment, is one of the best ways to reduce opiate-related deaths.[1,2,3]

Co-ordinated release from prison

The increased risk of death from overdose in the first weeks after release from prison is well documented.[5] Strategies to reduce this risk include increasing the availability of drug treatment in prison, pre-release counselling and overdose prevention information, co-ordination with the community to ensure continuity of treatment, and availability of social supports on release.

European research on risk factors for overdose *(continued)*

Individual risk factors for overdose

Drug use

- Topping up on a legitimate methadone prescription
- Using someone else's methadone prescription
- Preferring illegal drug use to prescribed methadone
- Not always taking prescribed medication, which may reduce drug tolerance and increase withdrawals and susceptibility to overdose
- Unintentionally taking too many drugs, due to unexpected heroin purity, lower tolerance, or ingesting unknown tablets
- More frequent use of illicit methadone
- Very high levels of drug intake with users experiencing difficulty in controlling their drug intake
- High levels of polydrug use and prescription drug use
- Reduced tolerance to opioids
- Benzodiazepine use
- Large quantities of alcohol
- Injecting cocaine
- Length of time that people have used drugs
- Sporadic use of heroin

Circumstances of overdose

- Slow overdose onset
- Two weeks after release from prison (compared to other times of liberty)

Experience of treatment

- Withdrawal from drug treatment
- Leaving treatment
- Periods of induction and transition, such as when drug users (re)enter or discontinue treatment
- Greater number of separate treatment episodes

Psychiatric/physical

- Suicidal ideation
- History of mental health problems, a current psychiatric diagnosis and prescription of psychotropic medicines
- Access to antidepressants, through genuine prescriptions, obtaining different antidepressants from different prescribers
- Feelings of indifference and carelessness
- High levels of hepatitis and cirrhosis

Social

- More drug injectors in the social network experiencing conflict with more network members
- Life events: recently experienced bereavement of someone close to them, a relationship breakdown, accommodation problems

Circumstances

- Injecting drug use in public places affords less opportunity to test the sample strength

Reproduced from Frischer *et al.* (2012), p.17

Reducing the availability of opiates

The United Nations Office on Drugs and Crime (UNODC) notes the rise in the number of overdose deaths owing to prescription opiates, particularly in the US.[3] It recommends specific strategies, including real-time monitoring of the prescription of opiates, reduced prescribing, and promoting greater awareness among health professionals of the risks of long-term prescribing for chronic conditions.

Preventing fatalities in the event of an overdose

Take-home naloxone is already available in five European countries as part of their overdose prevention strategies (see article on p. 13). Of note, the most recent figures from the National Drug-Related Deaths Index (NDRDI) show that 59% of all poisoning deaths in Ireland in 2011 involved more than one drug, in many cases a benzodiazepine along with one or more other substances.[6] Naloxone is only effective in reversing *opiate* overdose and therefore a range of strategies is needed to prevent overdose deaths when polydrug use is prevalent.

Another prevention strategy is to improve bystander response by providing information and training to enable those on the scene to recognise and respond to the overdose. Naloxone can be administered by bystanders (family, friends or other drug users) if they are properly trained.

The EMCDDA cites the availability of supervised drug consumption rooms which are targeted at a very specific group of users as another strategy to reduce fatalities in the event of overdose.[3] Seven European countries have such facilities. They are usually integrated into a service which offers a range of other harm reduction, medical and social services.

Conclusion

The issues involved in preventing overdose are summarised by Frisher *et al.* (2012):

> [T]here is evidence that many interventions may reduce overdose, particularly in settings where the drug user is in contact with treatment or emergency services. However, it is important to bear in mind the distinction between overdose prevention at the clinical and at the population level. At the clinical level, specific interventions are available and have been shown to be effective (e.g. pharmacological treatment). At the population level, where many drug users are not in contact with services, overdose reduction depends on behavioural change by drug users themselves (e.g. avoiding the mixture of opiates and other depressant drugs). Overdose prevention is a multifaceted problem. Purely technological interventions were thought likely to have a relatively limited impact. Rather, overdose involves personal and societal issues; only when these are addressed is the level of fatal overdose in Europe likely to decrease. (pp. 4–5)

(Suzi Lyons)

European research on risk factors for overdose *(continued)*

1. European Monitoring Centre for Drugs and Drug Addiction (2013) *Perspectives on drugs: preventing overdose deaths in Europe.* Lisbon: EMCDDA. www.emcdda.europa.eu/topics/pods/preventing-overdose-deaths
2. Frisher M, Baldacchino A, Crome I and Bloor R (2012) *Preventing opioid overdoses in Europe: a critical assessment of known risk factors and preventative measures.* Lisbon: EMCDDA. www.drugsandalcohol.ie/18701
3. UNODC and WHO (2013) *Discussion paper UNODC/WHO 2013. Opioid overdose: preventing and reducing opioid overdose mortality.* Vienna: United Nations. www.drugsandalcohol.ie/20068
4. Lynn E (2014) The overdose risk information (ORION) project. *Drugnet Ireland*, (48): 14. www.drugsandalcohol.ie/21212
5. Lyons S, Walsh S, Lynn E and Long J (2010) Drug-related deaths among recently released prisoners in Ireland, 1998 to 2005. *International Journal of Prisoner Health*, 6(1): 26–32. www.drugsandalcohol.ie/13332
6. Health Research Board (2014) *Drug-related deaths and deaths among drug users in Ireland: 2011 figures from the National Drug-Related Deaths Index.* www.drugsandalcohol.ie/21005

Preventing opiate-related deaths in Ireland: the naloxone demonstration project

One of the key priorities of the Health Service Executive (HSE) *National Service Plan 2014* is to improve health outcomes for people with addiction issues.[1] One of the actions related to this is the finalisation of the implementation plan for the National Overdose Prevention Strategy (unpublished). Investigating the possibility of enhanced availability of naloxone, a drug used to counter the effects of opiate overdose, is a key element of the HSE's overdose strategy (personal communication, Mr Joe Doyle, national planning specialist, HSE). This is important, considering opiates were implicated in 50% of all poisoning deaths in Ireland in 2011 (see article on drug-related deaths on p.14 of this issue).

The proposals on how to progress the naloxone demonstration project include:

- Identify stakeholders: to include a wide range of organisations, including community, families and voluntary services.
- Product choice: e.g. pre-filled syringe or nasal formulation.
- Legislative issues: naloxone is a prescription-only medication in Ireland and can only be dispensed by a pharmacist to a named person, for their use only, and can only be administered to that person by a trained healthcare professional (which includes certain ambulance service personnel).
- Cost and evaluation: to include pharma-economic evaluation, costs of training and supply of product.

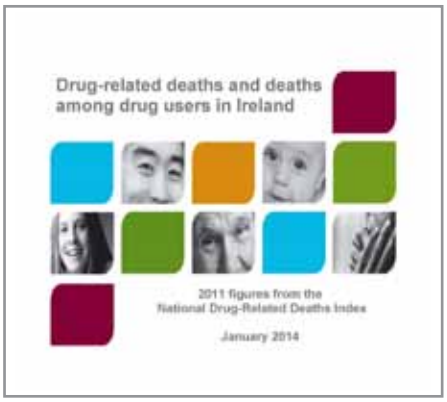
The Take Home Naloxone (THN) demonstration project started in Wales in 2009 is one of a number of UK models that have been documented.[2] Its main aim was to reduce drug-related deaths in Wales and it incorporated an independent evaluation at the end of the first year. This project was possible because of a change in the legal status of naloxone in 2005 in the UK which allowed any member of the public to administer naloxone in an emergency. The project took place in six pilot sites. Drug users, their friends and families were trained in overdose prevention, including how to identify risks, how to administer naloxone, and basic cardiopulmonary resuscitation. The independent evaluation of the project found an important outcome was that those who had been trained did not rely only on naloxone but also used other life-saving measures that they had been taught by the programme; they more frequently used the recovery position and called an ambulance than those who were not trained.

The project continues in Wales and has been expanded to different pilot settings. For example, in one major hospital emergency department, staff have been trained to give THN to clients at risk of overdose when leaving the hospital. For further information see http://tinyurl.com/nkrxmvy

(Suzi Lyons)

1. Health Service Executive (2013) *National Service Plan 2014*. Dublin: Health Service Executive. www.drugsandalcohol.ie/21092
2. Bennett T, Holloway K (2011) *Evaluation of the Take Home Naloxone demonstration project*. Merthyr Tydfil: Welsh Assembly Government. http://wales.gov.uk/docs/caecd/research/110627naloxonefinalreporten.doc

Latest figures on drug-related deaths published



The latest national figures on drug-related deaths in 2011 have been published.[1] The figures in this update supersede all previously published figures. Similarly, figures for 2011 will be revised when data relating to new cases become available.

In the eight-year period 2004 to 2011, a total of 4,606 deaths by drug poisoning and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 2,745 were due to poisoning and 1,861 were deaths among drug users (non-poisoning) (Table 1). There were 607 deaths in 2011, compared to 597 in 2010.

Table 1 Number of deaths, by year, NDRDI 2004 to 2011 (N=4,606)

	2004	2005	2006	2007	2008	2009	2010	2011
All deaths	431	503	561	630	624	653	597	607
Poisoning (n=2,745)	267	300	326	389	386	374	338	365
Non-poisoning (n=1,861)	164	203	235	241	238	279	259	242

Poisoning deaths in 2011

The increase in the total number of drug-related deaths in 2011 is due entirely to an increase in the number of poisoning deaths, which rose from 338 in 2010 to 365 in 2011 (Table 1). As in previous years, the majority (72%) were male. The median age of those who died was 39 years, again similar to previous years.

In 2011, alcohol was, once again, the drug most commonly involved in poisoning deaths (37%); however, several new trends emerged. Over half (59%) of all poisoning deaths involved more than one drug (polydrug use), with a total of 215 cases, a 28% increase on the 2010 figure of 168 Additionally, the number of deaths where prescription drugs were implicated increased sharply compared to 2010 figures. The number of deaths where benzodiazepines were implicated increased by 61%, to 166 in 2011 compared to 103 in 2010. There was also a steep increase in the number of deaths where antidepressant drugs were implicated, from 66 in 2010 to 96 in 2011. In addition, the number of deaths where methadone was implicated increased to 113, compared to 60 in 2010.

The reasons behind these upward trends are not yet clear and further analysis is needed to begin to understand the factors involved. What is known is that there was no change in the methodology used by the NDRDI between 2010 and 2011. What is also known is that 68% of those who died where methadone was implicated were not registered on the Central Treatment List (of people receiving methadone substitution treatment) at the time of their death.

The number of poisoning deaths in which heroin was implicated continues to decline, falling by 17% to 60 in 2011, compared to 72 in 2010. It is of note that similar trends were observed in Scotland during the same time period.[2]

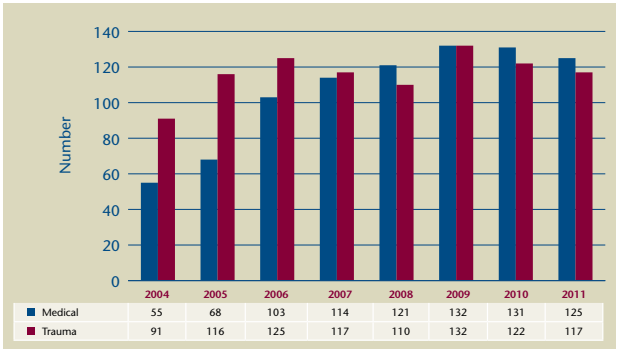


Figure 1 Non-poisoning deaths among drug users, NDRDI 2004 to 2011 (N=1,779)

Non-poisoning deaths in 2011

The number of non-poisoning deaths recorded among drug users dropped for a second year, to 242, compared to 259 in 2010 (Table 1). These deaths are categorised as being due either to trauma or to medical causes (Figure 1).

Deaths due to trauma

The number of deaths due to trauma decreased in 2011, to 117 deaths, down from 122 in 2010 (Figure 1). The majority (71%) of those who died were aged under 39 years. The median age was 29 years. As in previous years, the majority were male (86%). The most common causes of death due to trauma were hanging and road traffic collisions. Even though there has been a slight overall reduction in the number of traumatic deaths, it is notable that there has been a rise in the number of deaths due to hanging, from 49 deaths in 2010 to 65 in 2011.

Deaths due to medical causes

The number of deaths due to medical causes decreased slightly in 2011 (Figure 1). The majority (60%) of those who died were aged between 30 and 49 years. The median age was 43 years. Males accounted for 76% of those who died. The most common medical causes of death were cardiac events and liver diseases.

(Suzi Lyons and Ena Lynn)

1. Health Research Board (2014) *Drug-related deaths and deaths among drug users in Ireland: 2011 figures from the National Drug-Related Deaths Index*. www.drugsandalcohol.ie/21005
2. National Records Scotland (2012) *Drug related deaths in Scotland in 2011*. Edinburgh: National Statistics Scotland. www.gro-scotland.gov.uk/files2/stats/drug-related-deaths/2011/drug-related-deaths2011.pdf

NDTRS drug treatment data for 2011 and 2012 available on line

Drug treatment data for 2011 and 2012 from the National Drug Treatment Reporting System (NDTRS) are now available in the DRUG DATA pages of the NDC website at www.drugsandalcohol.ie. The database now contains nine years of drug and alcohol treatment data that can be searched to produce customised reports. You can run analyses on the data based on up to eight different types of drug, and alcohol, in various combinations. The variables available for analysis include year, age group, gender and place of residence (county, HSE region, LHO, regional or local drugs task force area). The report of your analysis can then be exported into Excel.

When interpreting the data, it should be remembered that each NDTRS record relates to a treatment episode (a case) and not to a person. Because there is currently no unique health identifier system in place in Ireland, the same person can be counted more than once in a reporting year if they had more than one treatment episode in that year.

Before using this resource you will be asked to accept a number of terms and conditions. These conditions protect the identity of NDTRS clients and the integrity of the data. We also ask that the NDTRS is acknowledged when data from the tables are used in a publication or presentation, and that the NDC and the NDTRS team both receive copies of any publication in which these data are used.

Stakeholder consultation on Hidden Harm

'Hidden harm' (HH) is the term now most often used to describe the experience of children living with, and affected by, problem alcohol and other drug use by parents. The term conveys the two key features of that experience: these children are frequently not known to health or social services, and they are exposed to harm, often through physical or emotional neglect.[1,2,3] Experience from other countries has shown that despite evidence to show the negative impact of HH, there is lack of policies on how to effectively address HH. The other two main areas where HH is of concern are domestic violence and parental mental health disorders.

In June 2013 a project management steering group on hidden harm was established, led by the National Social Inclusion Office, Mental Health and Addiction Services North West, and the new Child and Family Agency.

The group has already identified two national practice sites, Donegal and the Midlands, to begin HH practice working, with the initial focus on the needs of children and families where there is parental problem alcohol and/or other drug use. The overall aim is to raise awareness and to work with children affected by HH but also to develop a HH protocol to ensure the welfare and protection of children through interagency working aimed at early identification and support.

As part of this process, a stakeholder consultation meeting took place on 28 January 2014 in Sligo. The aim of this consultation was to learn from the experience and practice of those currently working in the area, including health, social work, and drugs and alcohol services across the two national practice sites, in order to inform the strategy for HH nationally and also to contribute to the current policy and practice debate in this sensitive and difficult area.

The objectives of the consultation were to:

- promote open dialogue on appropriate responses to children and families whose lives are affected by drug and alcohol use;
- gain a baseline understanding of awareness pertaining to HH among practitioners;
- draw on the views and experiences of stakeholders;
- inform the current practice debate on HH;
- identify current practice in responding to HH;
- identify practice issues that may pose a barrier to addressing HH; and
- inform the development of a national practice guide for addressing HH.

The meeting was opened by Ms Marion Rackard, National Social Inclusion Office, followed by a welcoming address from the chair, Mr Fred McBride, newly appointed chief operations officer of the newly created Child and Family Agency. He spoke about three key objectives for the HH process: a clear policy direction; joint integrated protocols; and political ownership of the parameters of risk management. Then Mr Joe Doyle, National Social Inclusion Office, gave a comprehensive overview of the background to the national policy documents which had led to this initiative. This was followed by a presentation by Dr Aisling Gillen of the Child and Family Agency in which she explained the rationale behind the focus on HH. She outlined the key elements built into the HH steering group action plan, including supporting practitioners and partnerships for cohesive working relationships; the need to develop national practice guidelines on addressing problem parental alcohol and other drug use; and the need to develop a framework for delivering on HH inclusive of a national strategy, protocol, suggested performance measures and monitoring processes.

Dr Joy Barlow OBE (pictured) gave a powerful presentation about the Scottish experience, including mistakes made and lessons learnt. She spoke about the importance of early identification of children at risk, the need to estimate

Hidden Harm consultation *(continued)*

numbers, the importance of staff training and development, and partnership. She also noted that, based on the Scottish experience, Ireland now had an opportunity to act given the priority problem alcohol use now has. She stated that the 2011 report *Hidden realities* provides baseline data on the number of children affected by parental alcohol use.[4]

Presentations by speakers from Northern Ireland followed, from Ms Cathy Mullan and Mr Davis Turkington, both from the HH Public Health Agency, and Ms Cathy Comiskey, child and family liaison practitioner. They gave very useful, interesting and practical accounts of how they had worked through the process of developing a protocol, setting out roles and responsibilities, implementing policies and how this all works in reality.[5,6] Videos and powerpoint presentations delivered on the day are available at www.drugs.ie/features.

This was followed by a facilitated structured round-table discussion among those attending the meeting, addressing a series of questions, the outcome of which will inform the ongoing process.

There are two more consultations planned to feed into this process:

- Phase 2: Views of families
- Phase 3: Views of commissioners, managers, practitioners and researchers working in health, social work, and drugs and alcohol services and other relevant departments, e.g. justice

The Substance Misuse and Child Welfare Special Interest Group in Northern Ireland is a forum for those interested in this area, and is now open to all practitioners both North and South. The aim of the group is to:

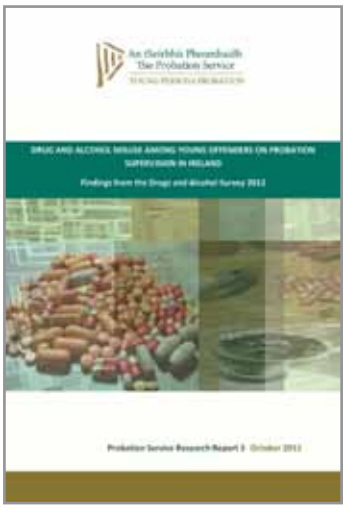
- share and discuss the implications of research findings;
- disseminate developments in policy and practice;
- promote the evidence base informing policy and practice developments; and
- network and share resources.

Members will receive regular updates through a Listserv mailing list and seminars will be organised. To become an email member contact David Hayes at d.hayes@qub.ac.uk

(Suzi Lyons)

1. Advisory Council on the Misuse of Drugs (2003) *Hidden harm: responding to the needs of children of problem drug users*. London: Advisory Council on the Misuse of Drugs. www.drugsandalcohol.ie/5456
2. Scottish Executive (2004) *Hidden harm: Scottish Executive response to the report of the inquiry by the Advisory Council on the Misuse of Drugs*. Edinburgh: Scottish Executive. www.gov.uk/government/uploads/system/uploads/attachment_data/file/120619/0012816.pdf
3. The Council of Australian Governments (2009) *Protecting children is everyone's business: national framework for protecting Australia's children (2009–2020)*. Canberra: Commonwealth of Australia. www.communities.qld.gov.au/resources/childsafety/child-protection/national-framework.pdf
4. Hope A (2011) *Hidden realities: children's exposure to risks from parental drinking in Ireland*. Letterkenny: North West Alcohol Forum. www.drugsandalcohol.ie/16250
5. Public Health Agency, Health and Social Care Board (2009) *Hidden harm action plan: responding to the needs of children born to and living with parental alcohol and drug misuse in Northern Ireland.* Belfast: Department of Health, Social Services and Public Safety. www.drugsandalcohol.ie/15570
6. Public Health Agency, Health and Social Care Board (2013) *Regional Joint Service Agreement – Hidden Harm protocol.* Belfast: Public Health Agency, Health and Social Care Board.

Investigating the links between substance misuse and crime among young offenders



A better understanding of the nature of the connection between drug use and offending has implications for drug and crime prevention and for treatment and criminal justice interventions.[1] A major impediment in this area in Ireland, however, is the absence of research and data from within the criminal justice system. Although annual data are available from the Central Statistics Office and the Courts Service on the number of drug offences (infringements of drug laws such as possession and supply) that are committed, and from the Irish Prison Service on the number of prison committals for drug offences, data are not routinely available on the number of drug-related offences committed as a consequence of substance misuse, whether alcohol-related public order offences or thefts committed by dependent drug users to feed their drug habit, for example. The development of a knowledge base of this kind often requires further analysis of the data compiled within agencies of the criminal justice system.

In 2012, the Probation Service published the findings of the first large-scale, nationwide survey of drug and alcohol misuse among the adult offender population on probation supervision,[2] followed in late 2013 by the report of a similar survey of young offenders (aged 20 years or under) who were on probation supervision.[3]

Links between substance misuse and crime *(continued)*

The main objectives of the latter survey were:

- to determine the number of young offenders under probation supervision who had misused drugs and/or alcohol;
- to investigate the nature and frequency of drug and alcohol misuse;
- to examine the context within which drug and alcohol misuse occurred;
- to ascertain whether a relationship exists between drug misuse and offending behaviour and alcohol misuse and offending behaviour;
- to identify the range and nature of engagement with drug and alcohol treatment services. (p.9)

The survey population was identified by means of the Probation Service electronic case tracking system. Probation officers completed and returned survey questionnaires relating to 721 offenders on their casebooks on 3 December 2012, of whom 647 (89.7%) were male and 74 (10.3%) were female.

Of the 721 cases surveyed, 628 (87%) were identified as having misused drugs, alcohol or a combination of both; 12% had misused drugs only, and 12% had misused alcohol only. Male and female offenders had relatively similar rates of substance misuse. Alcohol was the substance most often misused on a weekly basis (39.8% of males and 43.6% of females), followed by cannabis (20.4% of males, 14.5% of females). Females were 'less likely to have misused both drugs and alcohol and significantly less likely than males to have misused drugs alone (1%). However females were more likely than males to have misused alcohol only (16% compared to 12%)' (p.17). Twenty-six per cent of females were reported to have abstained entirely from either drug or alcohol abuse, compared to 11% of males. A higher percentage of females (14.5%) than males (8.9%) misused prescription drugs (p.20).

The study also explored the 'gateways and influences' which surround the misuse of drugs and alcohol by young offenders. Alcohol was recorded as the most common substance first misused, followed by cannabis. A higher percentage of females than males were reported to have started with alcohol (females 70.9%, males 55.7%), while cannabis as the first substance used was higher for males (males 35.3%, females 23.6%). While substance misuse was reported as commencing as young as 9 years, the median age was 14 years. Consistent with most other studies in this area, more than 80% of offenders first engaged in substance misuse with their peers. Of the 628 offenders who had misused a substance, 38.9% had parents with a history of substance misuse, while 55.6% did not. In explaining this phenomenon, and citing a UK study, the report states that 'alcohol consumption in Great Britain and Ireland can only be appreciated in the context of a "wet culture", whereby young people's drinking is essentially "normal" behaviour, part of a wider socialisation process, reflecting adult practices' (p.25).

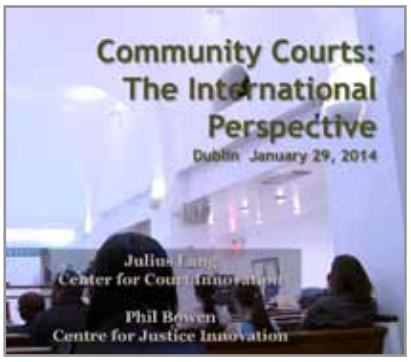
With regard to the link between substance misuse and crime, in more than 80% of cases substance misuse was linked, in the professional opinion of the probation officer, to current offending. Alcohol was the substance most frequently linked to offending for 61.7% of females and 43.8% of males. Drug misuse on its own was linked to a relatively small amount of offending. Public order was the most common offence category linked to offending and 'in nearly 70% of those cases alcohol was the substance of misuse' (p.30). In cases of assault, over half of the cases identified alcohol as the substance of misuse. Again, these findings are consistent with those of earlier Irish research in this area.[4] Over half of the survey population had attended some form of drug/alcohol treatment, the majority of whom were aged between 18 and 20 years.

One of the key performance indicators under the research/ information pillar of the current drugs strategy is comprehensive and timely reporting systems for the 'progression of offenders with drug-related offences through the criminal justice system'.[5] Action 55 proposes as an area of research 'the impact of alcohol and drugs on the Irish health and justice systems'. This initiative by the Probation Service makes an important contribution in this respect.

(Johnny Connolly)

1. For a general discussion see Connolly J (2006) *Drugs and crime in Ireland*. HRB Overview Series 3. Dublin: Health Research Board.
2. Martyn M (2012) *Drug and alcohol misuse among adult offenders on probation supervision in Ireland: findings from the drugs and alcohol survey 2011*. Navan: The Probation Service. www.drugsandalcohol.ie/18746. See also Connolly J (2013) Investigating the links between substance misuse and crime. *Drugnet Ireland*, 45: 15.
3. Horgan J (2013) *Drug and alcohol misuse among young offenders on probation supervision in Ireland*. Navan: The Probation Service. www.drugsandalcohol.ie/21333
4. Institute of Criminology (2003) *Public order offences in Ireland: a report by the Institute of Criminology, Faculty of Law, University College Dublin for the National Crime Council*. Dublin: Stationery Office. www.drugsandalcohol.ie/5437
5. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. (p.97).

Problem solving justice – establishing a community court in Dublin



The Dublin City Business Association (DCBA) has called for the establishment of a community court as a means of addressing low-level crimes such as vandalism, theft, anti-social behaviour, drug use and drug dealing in the capital. Addressing a seminar organised by the DCBA in January 2014, its CEO David Brennan said:

> We seek a system that manages the individual and not the process. We envisage a non-adversarial justice system that deals with the underlying causes of the offences and seeks to help the person and provide relevant support services to the perpetrators of these low level crimes and reduce reoffending. We ask the Government to consider establishing a working committee to establish a pilot for Community Courts in the capital.[1]

The seminar also heard presentations from Julius Lang of the Centre for Court Innovation in New York and from Phil Bowen of its affiliate organisation in the UK.[2] Following the seminar both speakers addressed the Joint Oireachtas Committee on Justice, Defence and Equality which had convened a meeting to discuss the feasibility of introducing such a community court system.[3]

There are currently more than sixty community courts in operation internationally, mostly in the United States where they began, but more recently in South Africa, England, Wales and Scotland, Australia and Canada.[4] In a 2007 report making the case for community courts in Ireland,[5] the National Crime Council (NCC) recommended the establishment of such a court in Dublin's inner city to deal with 'quality of life offences committed in the Store Street and Pearse Street Garda station catchment areas' (p.7).

Community courts, sometimes called community justice centres, have a number of common characteristics that differentiate them from traditional courts. In particular, according to the NCC report, community courts:

- are designed to help defendants to solve the problems that underlie their criminal behavior;
- hold them to account for the specific incidents that brought them to court;
- consult with the local stakeholders to set and accomplish priorities;
- are pro-active in preventing crime rather than merely responding when crime has occurred;
- bring the criminal justice agencies (courts, prosecutors, defence lawyers and police) into close co-ordination to address community issues; and
- strive to create an atmosphere which is conducive to engaging communities. (p.16)

With regard to the last objective, community courts are normally located in a particular locality and their jurisdiction is limited to that neighbourhood. They are presided over by a dedicated judge who, as a consequence, can develop an in-depth understanding of the problems in the area and a familiarity with local stakeholders,supports and services. The logic behind this approach was explained by Julius Lang in describing to the Oireachtas Committe the setting up of the first community court in Times Square, New York, in the early 1990s. The crime problem facing Times Square was 'a combination of complex social, economic, health and other issues and, as such, it defies easy solutions. … It was a type of crime that did its damage through an accumulation of relatively small but constant insults to the social fabric' (p.3). Times Square had become a 'mecca for the small and ugly, including street prostitution, open-air drug dealing, drunken brawling, assaults, shoplifting and illegal street trading' (p.4). The model adopted in response was

> a court with a geographic focus which would harness the power of the justice system to work with the community to solve local problems. …typical punishment consists of a combination of a community restitution assignment and mandated social services. These responses are delivered quickly, not days or weeks after the fact, often on the same day or next day after sentencing. (p.4)

Evaluations of community courts have provided mixed results. Philip Bowen, in his presentation to the Oireachtas Committee, explained that various evaluations have found that community courts can lead to reductions in the use of jail sentences, increased compliance with community-based court orders, decreases in crime such as prostitution and illegal street trading and positive cost-benefit outcomes. On the other hand, the recent closure of the North Liverpool Community Justice Centre was prompted by the low caseload coming before the court and the finding that the project did not reduce re-offending at any greater a rate than the UK average.[4]

In advocating the establishment of a community court in Dublin, the NCC recommend that its remit should primarily involve responding to public order offences, most of which, the evidence shows, are alcohol related.[6] In response to drug-related offences, a community court could also function as a gateway to treatment services, or indeed, to the Drug Treatment Court, which has been operating in the city for many years. Substance-related crime and anti-social behavior in Dublin city centre is not a new phenomenon, but it is one that has attracted a great deal of attention in recent years.[7] The establishment of a community court might represent a novel approach to this old issue.

(Johnny Connolly)

1. Dublin City Business Association (2014, 29 January) *Dublin City Business Association calls for a working committee to establish community courts for the capital.* Press release issued by the DCBA at its seminar in Dublin. www.dcba.ie

Problem solving justice *(continued)*

2. Both presentations can be downloaded from the website of the DCBA at www.dcba.ie
3. Lang J and Bowen P (2014, 29 January) *Parliamentary Debates Dáil Éireann (Official report: unrevised)*. Joint Committee on Justice, Defence and Equality debate. Community courts system: discussion. http://oireachtasdebates.oireachtas.ie/
4. Henry K and Kralstein D (2011) *Community courts: the research literature. A review of findings.* Washington: US Bureau of Justice Assistance. www.courtinnovation.org/research/community-court-research-literature
5. National Crime Council (2007) *Problem solving justice: the case for community courts in Ireland.* Dublin: Stationery Office. www.crimecouncil.gov.ie/index.html
6. See article on Probation Service report in this issue. See also: Institute of Criminology (2003) *Public order offences in Ireland: a report by the Institute of Criminology, Faculty of Law, University College Dublin for the National Crime Council.* Dublin: Stationery Office. www.drugsandalcohol.ie/5437
7. Strategic Response Group (2012) *A better city for all: a partnership approach to address public substance misuse and perceived anti-social behaviour in Dublin city centre.* Dublin: Strategic Response Group. www.drugsandalcohol.ie/17769

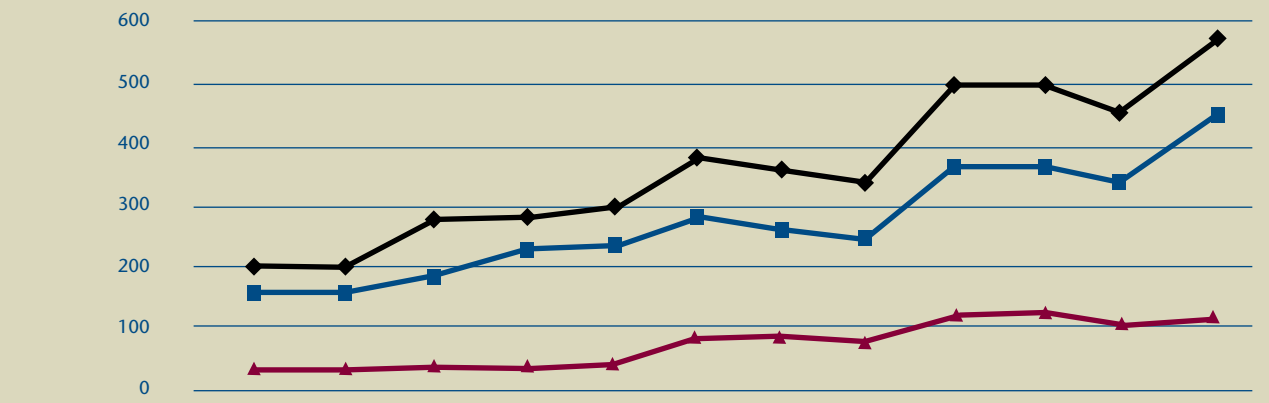
Pharmacy needle exchange in Ireland

In October 2011 the HSE rolled out the national pharmacy needle exchange programme, which is a partnership initiative between the Elton John Aids Foundation, the Irish Pharmacy Union and the Health Service Executive (HSE). The programme targets counties outside of Dublin and will run to September 2014. Once pharmacies have signed a service level agreement with the HSE, their contact details are passed on to the relevant HSE services so that they can promote access to sterile injecting equipment at the participating pharmacies and accept referrals for investigation and treatment.

There were 42 pharmacies providing needle exchange at the end of 2011 and this had increased to 71 by the end of 2012. There are pharmacies providing needle exchange in each regional drugs task force area (Table1) apart from those covering counties Dublin, Kildare and Wicklow, which are served by a mix of static and outreach needle-exchange programmes. The data used to prepare this article were collected from participating pharmacies by the HSE.

Table 1 Number of pharmacy needle exchanges at the end of 2011 and 2012

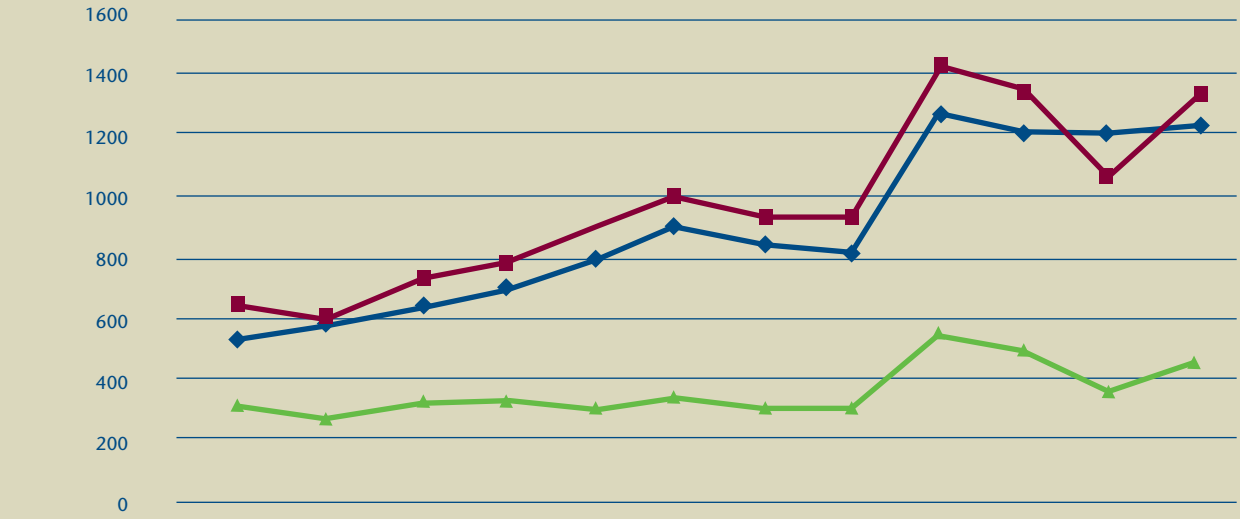
Regional drugs task force area	2011	2012
Midland (Longford, Laois, Offaly, Westmeath)	1	414
Mid West (Clare, Limerick, North Tipperary)	20	2464
North Eastern (Meath, Louth, Cavan, Monaghan)	101	1377
North West (Sligo Leitrim, West Cavan, Donegal)	0	4
Southern (Cork and Kerry)	199	3124
South East (Carlow, Kilkenny, Waterford, Wexford. South Tipperary)	250	3424
Western (Galway, Mayo, Roscommon)	0	250



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Unique Individuals	199	197	264	282	298	382	360	329	494	494	449	573
Male	158	152	185	233	243	296	274	247	380	380	354	459
Female	41	45	54	49	57	86	85	81	117	117	95	110

Figure 1 Number of individuals attending needle exchange, by gender, 2012

Pharmacy needle exchange in Ireland *(continued)*



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
No. of transactions	522	587	617	687	795	896	838	814	1249	1201	1186	1209
10 packs given out	617	594	770	788	907	986	961	698	1419	1342	1069	1272
10 pack returns	295	265	324	352	345	359	325	318	575	501	376	435

Figure 2 Numbers of transactions at needle exchange, packs distributed, and used packs returned, 2012

An average of 360 individuals attended pharmacy-based needle exchanges each month in 2012. The number of individual drug users using sterile injecting equipment increased by 188%, from 199 in January 2012 to 573 in December (Figure 1). Male attendees comprised 78% of individual attenders, and had an average age of 31 years; the average age of female attendees was 29 years.

The needle exchanges completed 10,601 transactions in 2012, distributing 11,693 packs; each pack contains 10 sets of injecting equipment. The number of transactions increased by 132%, from 522 in January 2012 to 1,209 in December and the number of packs distributed followed a similar trend (Figure 2). Each individual user received an average of 2.7 packs (27 needles and syringes) in a calendar month in 2012. Thirty-eight per cent of the injecting equipment provided by pharmacies was returned for disposal.

The pharmacy needle exchanges provides a link between harm reduction services and drug treatment services through referring individuals for bloodborne viral testing (253 in 2012), hepatitis B vaccination (165) and to tier three and tier four services (261).

(Jean Long, Joe Doyle and Denis O'Driscoll)

HSE services in 2014 – illicit drugs, smoking and alcohol misuse

Approved by the Minister for Health on 17 December 2013, the HSE's *National Service Plan 2014* sets out the type and volume of services the HSE will provide during 2014.[1] With the health services budget for the year reflecting cost reductions of €619 million, and against a backdrop of a reduction in overall health service funding of almost €4 billion since 2008 and staff reductions of over 10,000 in that time, the HSE's top priority in 2014 is to protect the volume, quality and safety of frontline services.

Social Inclusion Services

'Addiction issues' are addressed by Social Inclusion Services in the Primary Care Division of the HSE. Social Inclusion Services support equity of access to services and provide targeted interventions to improve the health outcomes of minority groups, including Irish Travellers, Roma, and other members of diverse ethnic and cultural groups, such as asylum seekers, refugees and migrants, lesbian, gay, bisexual and transgender service users. Specific interventions are provided to address addiction issues, homelessness and medical complexities.

The key priorities for 2014 that may be expected to have an impact on addiction issues are set out on p.37 of the plan:

- achieve improved health outcomes for persons with addiction issues;
- deliver on the national policy objectives of the national drugs strategy 2009–2016,[2] with specific reference to progressing implementation of relevant actions on early intervention, treatment and rehabilitation;
- implement recommendations from Health Service Opioid Treatment Protocol;
- implement recommendations with regard to Tier 4 in the residential addiction services report[3] within the context of available resources;
- evaluate the Pharmacy Needle Exchange Programme and make recommendations;
- finalise the implementation plan for the National Overdose Prevention Strategy;
- prioritise and implement Health Service actions in the report on a national substance misuse strategy;[4]
- implement recommendations of the national hepatitis C strategy[5] according to updated time frames and in line with existing resource constraints; and
- implement the specific health aspects of a housing-led approach to homelessness in line with the national homelessness policy statement.[6]

Key Performance Indicators for HSE Social Inclusion Services, 2014	Expected Activity/ Target 2014
Opioid Substitute Treatment	
No. of clients in opioid substitute treatment (outside prisons)	9,100
Substance Misuse	
No. and % of substance misusers **(over 18 years)** for whom treatment has commenced **within one calendar month** following assessment.	1,260 (100%)
No. and % of substance misusers **(under 18 years)** for whom treatment has commenced within **one week** following assessment	105 (100%)
Pharmacy Needle Exchange	
No. of unique individuals attending pharmacy needle exchange	700
Homeless Services	
No. and % of individual service users admitted to homeless emergency accommodation hostels/ facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	1,700 (85%)
Source: *Health service national service plan 2014*. p.38.	

Health and Wellbeing Division

Smoking and alcohol misuse are addressed by the Health and Wellbeing Division of the HSE, which provides people with knowledge, services and supports to help them live healthier and more fulfilled lives. In 2014, in order to reduce the chronic disease burden, this division has identified the following 'key priorities':

- support a package of programmes to reduce alcohol misuse;
- produce an implementation plan for recommendations identified in both the national substance misuse strategy report[3] and the 2013 tobacco control strategy;[7] and
- integrate and develop a one-stop model for all smoking cessation services in the health service.

Among the key performance indicators for the Health and Wellbeing Division are two tobacco-related indicators:

- Number of frontline healthcare staff trained in brief-intervention smoking cessation: 1,350

HSE services in 2014 *(continued)*

- Number of smokers receiving intensive cessation support from a cessation counsellor: 9,000

The Health and Wellbeing Division will also work to enforce the Public Health (Tobacco) Act and other tobacco control legislation, targeting areas of least compliance.

(Brigid Pike)

1. Health Service Executive (2013) *Health service national service plan 2014*. Dublin: Health Service Executive. www.drugsandalcohol.ie/21092/
2. Department of Community, Rural and Gaeltacht Affairs (2009) *National drugs strategy* (interim) *2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. www.drugsandalcohol.ie/12388/
3. Corrigan D and O'Gorman A (2007) *Report of the HSE working group on residential treatment & rehabilitation (substance users)*. Dublin: Health Service Executive. www.drugsandalcohol.ie/6382/
4. Department of Health (2012) *Steering group report on a national substance misuse strategy*. Dublin: Department of Health. www.drugsandalcohol.ie/16908/
5. HSE National Social Inclusion (2012) *National hepatitis C strategy 2011–2014*. Dublin: Health Service Executive. www.drugsandalcohol.ie/18325/
6. Department of the Environment, Community and Local Government (2013) *Homelessness policy statement*. Dublin: Department of the Environment, Community and Local Government. www.drugsandalcohol.ie/19346/
7. Tobacco Policy Review Group (2013) *Tobacco free Ireland*. Dublin: Department of Health. www.drugsandalcohol.ie/20655/

Review of Dublin North City and County addiction service

A recent high-level review of addiction treatment services in the Dublin North City and County area concludes that a substantial reconfiguration of services is needed to effectively respond to population needs and emerging national policy.[1] The report contains 14 recommendations, eight to reconfigure services and six to reconfigure operational elements (Table 1).

Table 1 Recommended changes to the Dublin North City and County addiction service

Service recommendations	Operational recommendations
Deliver addiction services around clinical care pathways for drugs *and* alcohol, with a focus on recovery.	All service users should have agreed care plans which should be reviewed and updated regularly
Organise addiction services to treat all addictions (including alcohol and stimulants) in multi-disciplinary teams which are locality based.	Locality teams should provide support to individuals with drug and alcohol problems who are treated by primary care services.
Develop specialist resources and services around dual diagnosis, pregnancy, hepatitis C, assisted withdrawal for individuals with complex needs, and children, young people and families.	All interventions should be evidence based and service providers should have appropriate training and supervision to ensure effective delivery.
Appoint a clinical director who should jointly chair the senior management team, and a designated clinical lead for each locality team and specialist services.	Assisted withdrawal (detoxification) services and rehabilitation services should be developed as a part of all care pathways.
Appoint a service manager who should jointly chair the senior management team; all staff should have clear lines of accountability.	Provide formal structures to enable service users to contribute to the design and evaluation of care.
Have in place a routine outcome monitoring programme; outcomes should link to agreed clinical and service performance measures	Appoint a designated implementation manager and establish a steering group to implement the recommendations in this report.
Develop a clinical governance structure to support the work of all clinicians in the addiction service.	
Assessment of need and regular reviews of identified need should be central to the delivery of addiction services.	

Source: Pilling and Hardy (2013), pp.6–7 .

Review of Dublin North services *(continued)*

The review team drew heavily on consultations with representatives from a range of staff groups, including psychiatrists, pharmacists, voluntary sector representatives, service users and outreach workers. In summarising the main issues to emerge from these consultations, the authors acknowledge that while many elements of the service work well:

> The current service configuration is sub-optimal, meaning that it is not always possible for staff to deliver care in line with an evidence-tiered approach…. The service currently consists of a number of professional/staff groups, some of whom appear to have limited formal interaction with one another…. There are also a number of ad-hoc arrangements in place, with staff providing good services but again these are often not properly integrated within the wider service system…. Services have typically evolved, often without an overall strategic direction, responding to specific issues or opportunities. (p.20)

The authors identify a lack of integration between the different elements of service provision. They also point out that, in the main, the primary functions of addiction treatment services across the area are to assess opioid dependence and dispense methadone. They see the scope of service provision needing expansion to prioritise responses to alcohol misuse, co-morbid mental health disorders, non-opiate drug misuse and the physical healthcare of service users. They also state that a detailed and comprehensive needs assessment is required to document the nature and level of services required by people across the area with addiction-related needs.

Finally, the authors recommend that 'in line with international opinion, the principle of recovery should underpin all treatment from the point of first contact' (p.20). They draw on the following definition of recovery: 'an individual, 'person-centred journey, enabling people to gain a sense of control over their own problems, the services they receive, and their lives and providing opportunities to participate in wider society' (p.22).

As the authors rightly point out, addiction recovery is becoming the guiding principle for substance use treatment in a number of jurisdictions. For example, US policy on substance use is increasingly promoting recovery and recovery support services,[2] while, closer to home, current drug policies in England and Wales[3] and in Scotland[4] give a prominent role to recovery. The EU action plan on drugs[5] call's on member states to implement recovery and social reintegration services as part of a wider demand reduction pillar.

This review is both insightful in reflecting on the past and current situation and illuminating in charting a reflective path to guide the future development of the Dublin North City and County addiction service. Grounded in the developing consensus of international research, the recommendations if implemented could transform the delivery of addiction services across the area and beyond. In the words of the review team,

> Implementing the recommendations in this report will not only bring the service in line with national policy expectations, but will place it in a strong position to become the leader in addiction treatment in Ireland. (p.34)

(Martin Keane)

1. Pilling S and Hardy R, with Psychological Interventions Research Centre (UCL) review team (2013) *Review of the Dublin North City and County addiction service.* Dublin: HSE Addiction Services. www.drugsandalcohol.ie/21143
2. Laudet AB and Humphreys K (2013) Promoting recovery in an evolving policy context: what do we know and what do we need to know about recovery support services? *Journal of Substance Abuse Treatment*, 45: 126–133.
3. UK Home Office (2010) *Drug strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life.* London: Her Majesty's Government.
4. The Scottish Government (2008) *The road to recovery: a new approach to tackling Scotland's drug problem.* Edinburgh: The Scottish Government.
5. Council of the European Union (2013) *EU action plan on drugs (2013–2016).* Brussels: Council of the European Union.

Substance misuse in the eastern counties of HSE South

The Health Service Executive (HSE) South published the report *Data co-ordination overview of drug misuse 2012* in November 2012.[1] This overview reports on treated substance misuse in the south-eastern counties of Carlow, Kilkenny, South Tipperary, Waterford and Wexford. The report comprises sections relating to treatment services and substance-related offences in the region.

The section on treatment services analyses data collected from statutory and voluntary drug and alcohol treatment agencies, acute general hospitals and psychiatric hospitals in the region. Data from the drug and alcohol treatment services are returned to the National Drug Treatment Reporting System in the Health Research Board.

Substance misuse in HSE South *(continued)*

The total number of individuals seeking treatment in 2012 was 3,719, a decrease of 17 on the 2011 figure. Some 236 concerned persons (family members or close friends of substance users) contacted treatment services in the south east in 2012.

Excluding clients who were assessed only and those who were treated for addictions other than substance misuse, the combined total of continuous care clients and new referrals treated in 2012 was 3,012. Of these:

- 67% were male and 33% were female.
- 6% were under the age of 18, and 23% were aged between 18 and 24.
- 56% were aged under 35.
- Alcohol (57%) was the most common main problem substance for which treatment was sought, followed by heroin (18%), cannabis (17%), benzodiazepines (3%) and cocaine (2%).

Since 2011 the numbers treated for alcohol as a main problem substance decreased by 7%, and for cocaine by 20%. There was a notable increase (54%) in the number treated for benzodiazepines as a main problem drug (Table 1).

According to the report, the increase in the numbers presenting for treatment for heroin may be owing to a new methadone clinic in South Tipperary and the expansion of the Waterford treatment service. In addition, at the end of 2012 there were 17 GPs in the region providing Level 1 services for 61 clients addicted to opiates, and services were supported by 54 pharmacies.

The first needle exchange service in the south east was developed in 2011 in Waterford. In 2012 there were an additional four such services operating from fixed sites – in Carlow, Kilkenny, Wexford and South Tipperary. Ten pharmacies in the region also provided needle exchange services in 2012.

A total of 2,052 clients exited the services in 2012. More than one third (35%) of these clients completed treatment; 26% refused further sessions or did not return for subsequent appointments; 18% withdrew as they considered themselves to be stable; 12% were transferred to another site for further treatment; 4% exited because of non-compliance; 4% exited for other reasons; and 0.5% had died.

The overview reports the most recent Garda data on drug offences published by the Central Statistics Office. The number of cases in the south east region in 2011 that gave rise to relevant proceedings were:

- Importation, cultivation or manufacture of drugs – 63 cases
- Possession for sale of supply, or for personal use – 1,243 cases
- Forged or altered prescriptions, or obstruction – 32 cases

(Joan Moore)

1. Kidd M (2013) *Data co-ordination overview of drug misuse 2012*. Waterford: HSE South. www.drugsandalcohol.ie/21262

Table 1 Main problem drug and numbers treated in 2010 and 2011

Main problem drug	2011	2012	+/-	%
Alcohol	1830	1705	-125	7%
Heroin	461	529	+68	15%
Cannabis	498	522	+24	5%
Cocaine	81	65	-16	20%
Benzodiazepines	63	97	+34	54%
Other opiate-type drug	39	39	-	-

Source: Data from Kidd (2013)

Fifteenth annual Service of Commemoration and Hope

On Saturday 1 February the National Family Support Network (NFSN) held its fifteenth annual Service of Commemoration and Hope, entitled 'Supporting Our Family', in remembrance of loved ones lost to substance misuse and related causes, and to publicly support families living with the devastation that substance misuse causes.

The service was preceded by a procession from the spire on O'Connell Street to Our Lady of Lourdes Church, Sean McDermott Street, led by the Garda band. Those in attendance included Counsellor Lucy McRoberts representing the Lord Mayor of Dublin, Bishop Eamonn Walsh, Fr Tim Wrenn and other religious representatives, as well as family members, friends, and many people working in this area. Music was provided by the soprano Nickola Hendy and Gardiner Street Gospel Choir.

In her address to the gathering, Sadie Grace of the NFSN spoke about the increase in poisoning deaths reported by the National Drug-Related Deaths Index, specifying the main drugs implicated in these deaths, namely; alcohol, benzodiazepine and antidepressants. She also mentioned the significant increase in deaths in which methadone was implicated and emphasised that behind these statistics are devastated families. Sadie spoke about the impact of substance misuse on children and extended family members, and about the sibling-support programme developed by the NFSN. She stressed the importance of providing services for children and support for grandparents taking on the role of caring for these children. The NFSN will continue to roll out its training programmes on responding to drug-related intimidation and the '5-step' method in different parts of the country.

Sadie acknowledged the growth of NFSN. evidenced by the presence of representatives from family support groups throughout the island of Ireland, and how vital it is that families are represented on decision-making bodies as they are directly affected by substance misuse. She urged that support of family members living with substance misuse be prioritised.

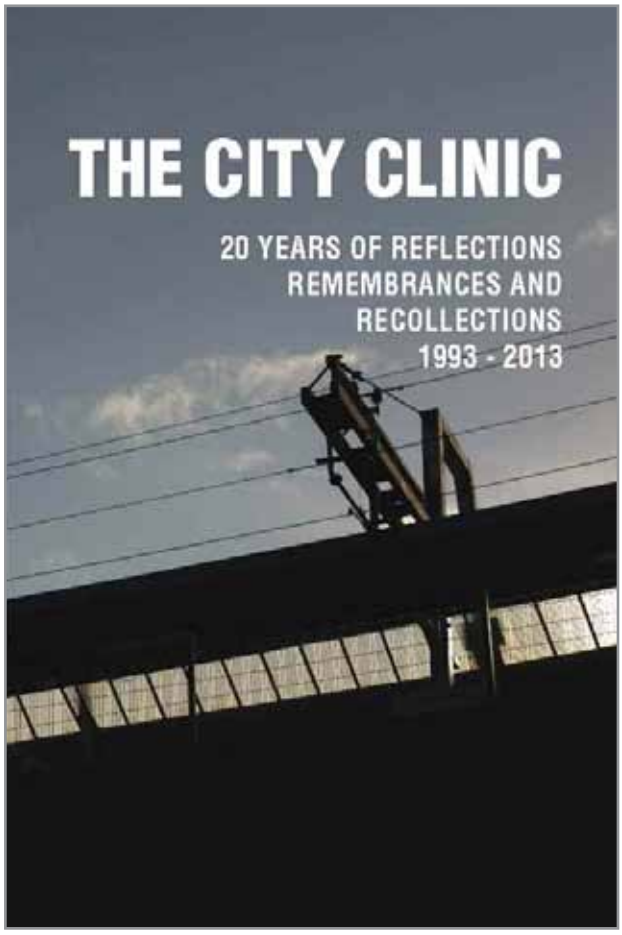
In his reflection, Fr Edmond Grace reflected on the pain families have gone through and the need for healing and hope. Brigid Sugrue, a member of the NFSN Bereavement Support Group, gave a moving testimony about her journey through living with the devastation of her daughter's drug addiction and subsequent death due to drug misuse. She sincerely acknowledged the tremendous work of the NFSN Bereavement Support Group and the vital support she has received from this group.

Anna Quigley of CityWide recited poetry by Emily Dickinson. Bill O'Dea of the Child and Family Agency read a message for the service on behalf of Pope Francis. Godfrey Chimbganda of the New Communities Partnership said a prayer. Kenny Hartnett, a member of UISCE (service users' representative forum), gave a very honest and emotional speech about his experience as a drug user. In his address Archbishop Diarmuid Martin spoke of how moving he found the service. He spoke of the broken lives, the isolation, fear, and path of destruction caused by substance misuse; however, he stressed that the path of hope must never be abandoned.

You can contact the National Family Support Network at 16 Talbot Street,,Dublin 1. Tel: 01 836 5168; email: info@fsn.ie; web: www.fsn.ie

(Ena Lynn)

City Clinic marks 20 years in addiction services



Ava Stapleton, counsellor; Des Crowley, GP co-ordinator; and Jo-Anne Sexton, counsellor/ psychotherapist, at the launch

The City Clinic is a HSE-funded drug treatment centre in Amiens Street in north Dublin. Set up in April 1993 as a public health and harm reduction response to the inner city's growing heroin problem, the clinic celebrated 20 years of service in December 2013 with the launch of *The City Clinic: 20 years of reflections, remembrances and recollections 1993 –2013*.[1] The booklet, with contributions from current and former staff, clients and others associated with the clinic, traces the work and development of the clinic since its inception.

Contributors to the booklet share personal memories of the City Clinic over the past 20 years, including those who recall its early days, their memories of the drug situation at the time and of the events and people that led to the setting up of the clinic.

Dr Des Crowley states that the pattern of drug use and the service-user profile of clients of the City Clinic have changed over the past 20 years. Now, clients often have polysubstance drug and alcohol abuse problems, clients in treatment have an increasing age profile and their health and treatment needs are changing. There are significant levels of dual diagnosis among the clinic's patient group.

Dr Crowley also states that drug treatment services have changed radically over the last 20 years and that the success of the City Clinic is substantial. Clients have immediate access to treatment and a retention rate for those in treatment of 98%. He goes on to say:

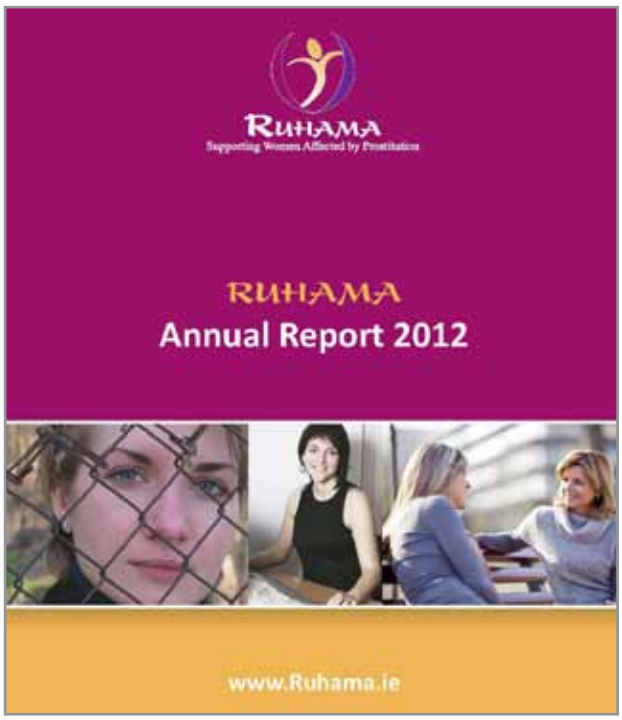
> The success in almost eliminating the spread of HIV infection among drug injecting community is a testament to the success of a harm reduction and public health approach to drug addiction … . The development of care planning and risk assessment has significantly improved patient outcomes across a range of measures. (p.7).

The City Clinic now has a staff of 25 multi-disciplinary health professionals, including admin staff, doctors, pharmacist, counsellors, nurses, outreach, general assistants, a rehab and integration worker and a midwife, to address the complex medical and psycho-social needs of clients. The clinic has treated over 1,300 patients since 1993 and adopts an inter-agency approach within the community to maximise all available treatment resources, so as to meet the care needs of clients.

(Ita Condron)

1. The City Clinic (2013) *The City Clinic: 20 years of reflections, remembrances and recollections 1993 –2013*. Dublin: The City Clinic. www.drugsandalcohol.ie/21037

Ruhama annual report 2012



Ruhama is a non-governmental organisation that works on a nationwide basis with women affected by prostitution. Ruhama provides support and assistance to women who are active in prostitution, have a history of prostitution, or are victims of sex trafficking. The latest annual report shows that the service worked with 258 women, of 32 different nationalities.[1] This article briefly describes some the main programmes of work reported by Ruhama for 2012.

Street outreach service

The Ruhama street service of 30 outreach workers, including staff and volunteers, worked 108 nights during 2012 and supported 72 women, some on multiple occasions; 10 of the women also engaged with Ruhama's casework service. The outreach service uses a purposely adapted vehicle which is referred to as 'the van' by service users throughout the report. The report documents the issues that women involved in street prostitution present with, including addiction, debt, homelessness, poor health, suicidal ideation and violence. Ruhama is particularly conscious of the negative role that addiction plays in the lives of women engaged in prostitution.

According to the report:

> A majority of women involved in street prostitution who accessed Ruhama services via the Outreach Van in 2012 led chaotic lives due to their drug misuse. Ruhama has noted that this particular cohort of women may not access the full services offered, particularly those available in education and development. Ruhama has proactively engaged with low threshold drugs services to ascertain what kind of interaction with education best suits the client needs, and with this in mind is developing a number of once-off workshops that women could access without having to sign up for regular classes. (p.15)

Casework

In 2012, there were 170 women in casework; 45 were new cases in general casework and 18 were new cases in victims of trafficking casework. The other 107 women were in casework from before the start of 2012. Casework involves the woman working individually with a caseworker to identify goals and address pertinent issues and needs in a planned way; the woman may also receive emotional support through counselling. Women who are deeply traumatised are also offered psychotherapy and some may benefit from art therapy. It usually takes approximately two years for a woman affected by prostitution to work through a care plan.

Education and development

Providing education and development services is referred to as a cornerstone of Ruhama's work. In 2012, 88 women engaged with Ruhama's education and development programme, an increase of 14% on the 2011 figure. Table 1 provides a detailed breakdown of the numbers of women and the activities they engaged with.

Additional services

Ruhama employs a specific worker to assist women to access suitable housing and accommodation; this service also assists women to access social welfare benefits and entitlements. In 2012, 33 women availed of Ruhama's resettlement support service. Assisting and supporting women to exit prostitution and to deal with the emotional and material experience of prostitution are key objectives of the organisation, as is its mission to support women to (re)gain their independence and eventually exit the services provided by Ruhama. The annual report shows that, in the course of 2012 Ruhama had been able to close the case files on 49 clients, meaning that the women had worked through their care plans and were no longer reliant on the services.

Table 1 Development and education activities engaged in and number of participants

Activity	Participants	Activity	Participants
Developed a career path plan	47	Engaged in group classes	33
Had one-to-one study skills	10	Worked on developing CVs	50
Did IT training	9	Learned English as second language	22
Started FETAC courses	11	Applied for third-level/further education or training	52
Completed FETAC courses	7	Received financial support to assess education	45

Source: Ruhama (2013), p.14.

Ruhama annual report 2012 *(continued)*

Conclusion

The annual report compiled by Ruhama and briefly described in this article is a useful insight into the nature and extent of work undertaken by the organisation with women affected by prostitution and human trafficking. However, work of this kind with such vulnerable and marginalised people can rarely be captured by reference to numbers and categories.

In the words of the chairperson of Ruhama:

> In this report we read many statistics, and behind each one is an individual woman's story, a personal experience, where she has been trafficked, coerced or otherwise socialised into a life which she now wishes to leave, but where her escape may be threatened by danger, fear and absence of options. (p.3)

(Martin Keane)

1. Ruhama (2013) *Ruhama annual report 2012*. Dublin: Ruhama. www.drugsandalcohol.ie/20863

Inchicore Bluebell team launches strategy document

Minister Alex White TD *(Photo by Karen Stein Photography)*

On 5 December 2013 Alex White TD, Minister of State with responsibility for the National Drugs Strategy, launched the Strategic Plan 2014–2017 of the Inchicore Bluebell Community Addiction Team (IBCAT).[1] Celine Martin, project director of the strategic review team, introduced the event, which was followed by a screening of the 'Taking Stock' media arts project by Joe Lee. This moving piece of work gave a snapshot of the lives of service users in their own words. The event was also addressed by Conor Daly, chairperson of the review team.

The plan outlines the research carried out by IBCAT among all stakeholders in the service – service users, local community groups, residents, staff and health professionals.

The main findings of the research are outlined below.

- Polydrug use is the norm for service users, with most clients using two or more substances.
- Alcohol and herbal cannabis are presenting as growing problems.
- Heroin, benzodiazepine and methadone use is clearly evident among service users.
- Family members, especially children, significantly benefit from the services provided through a community model of addiction treatment.
- Wider effects of addiction on the local communities are providing new challenges that need intervention.

The rates of drug and alcohol use identified highlight the huge challenges facing policy makers and care providers. It is hoped that the information contained within this plan will provide a unique insight into current and emerging needs.

For further information or to download a copy of the plan, please go to www.icdt.eu

(Vivion McGuire)

1. Inchicore Bluebell Community Addiction Team (2013) *Strategic Planning document 2014–2017*. Dublin: ICDT. www.drugsandalcohol.ie/21049

National Documentation Centre: new and updated resources

Online tutorials

To help you get the most value from our website we have created two short tutorials on using the National Documentation Centre on Drug Use (NDC), Ireland's drugs library. Each video is about five or six minutes long and is divided into separate sections for easy navigation. A text version of each is also available. On the NDC home page (www.drugsandalcohol.ie) click on TUTORIALS on the orange toolbar to get to the videos:

1. Overview and introduction to NDC website
2. Searching the collection

Factsheets

The key resources section on the home page of the NDC website includes Factsheets on cannabis, cocaine, opiates, and sedatives. The Factsheets contain the most recent published data on these drugs and can be accessed via the links below.

Factsheet: Cannabis – the Irish situation (December 2013) www.drugsandalcohol.ie/17307

Factsheet: Cocaine – the Irish situation (January 2014) www.drugsandalcohol.ie/17308

Factsheet: Opiates – the Irish situation (January 2014) www.drugsandalcohol.ie/17313

Factsheet: Sedatives and tranquillisers – the Irish situation (January 2014) www.drugsandalcohol.ie/19644

From *Drugnet Europe*

Kick-off: Joint action on reducing alcohol-related harm

Cited from article by Maria Moreira in *Drugnet Europe* No. 85, January–March 2014

Harmful and hazardous alcohol use is one of the main causes of premature death and avoidable disease in the EU today. Highlighting the importance of this issue, the European Commission (EC) is funding the *Joint action on reducing alcohol-related harm* (RARHA) project, which was launched in Lisbon on 31 January. … [T]he initiative involves 32 associated partners and 28 collaborating partners from both EU and non-EU countries. The EMCDDA is among the project's associated partners and also sits on its Advisory Group.

…The project aims to mobilise countries to develop common approaches in line with the EU alcohol strategy, including: developing methodologies to conduct alcohol surveys and pool data for comparative assessments; translating scientific evidence and knowledge into practical implications for good practice in alcohol-related interventions; and producing a toolkit of potentially transferable interventions with evidence of effectiveness and cost estimates.

For many years, there has been considerable policy concern about the interaction between alcohol and drug use in Europe. The EMCDDA's own remit was broadened in 2006 to include the monitoring of polydrug use, where illicit drugs are taken in combination with licit substances or medication.

For more, see www.emcdda.europa.eu/news/2014/sicad-rarha-conference

Focus on multidimensional family therapy

Cited from *Drugnet Europe* No. 85, January–March 2014

The family can play a vital role in addressing the issue of substance use disorders among adolescents. This is according to the latest edition in the 'EMCDDA Papers' series — *Multidimensional family therapy for adolescent drug users: a systematic review* — released on 6 February.

Adolescence is a period in human development during which individuals are more prone to risk-taking and less prone to impulse control. Some young people experiment with both licit and illicit substances during this time and this can have an impact on their behaviour, their relationships with others and their functioning in society. The new report explores multidimensional family therapy (MDFT), a form of inclusive therapy involving the young person, their family and their environment. Based on five studies carried out in the United States and the EU, the paper shows how this holistic approach can deliver promising results that are visible both during, and after, therapy. For more, see www.emcdda.europa.eu/publications/emcdda-papers

Exploring methamphetamine trends in Europe

Cited from *Drugnet Europe* No. 85, January–March 2014

Concerns about the availability and use of methamphetamine in Europe have been growing for some time. Historically, use of the drug has been confined largely to the Czech Republic and Slovakia. However, reports of increasing methamphetamine use from different European countries in 2012 and 2013 sparked an interest in investigating this topic further. The EMCDDA has responded with *Exploring methamphetamine trends in Europe* which aims to increase the overall understanding on this drug in Europe. The 'EMCDDA Paper', released on 31 January, follows trendspotter meetings held at the agency in September 2013. The report focuses on production and trafficking issues, prevalence and patterns of use, health and social harms, and responses to the problem. For more, see www.emcdda.europa.eu/publications/emcdda-papers

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). It is available at www.emcdda.europa.eu

If you would like a hard copy of the current or future issues, please contact:

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Knockmaun House
42–47 Lower Mount Street
Dublin 2

Tel: 01 234 5148
Email: drugnet@hrb.ie

Recent publications

Journal articles

The following abstracts are cited from recently published journal articles relating to the drugs situation in Ireland.

Library value and impact: taking the step from knowing it to showing it

Dunne M, Nelson M, Dillon L and Galvin B
Library and Information Research, 2013, 37(116).
www.drugsandalcohol.ie/21577

The National Documentation Centre on Drug Use (NDC) is a unique Irish information resource that embraces elements of several library types: national, public, special, academic, digital, and health. This paper presents the results of an evaluation study carried out by NDC staff in two parts, a value survey and impact interviews. Both quantitative and qualitative methods were used to examine aspects of the value and impact of the NDC's resources and services. Many elements of our approach worked well and contributed to the achievement of our aims and objectives. We outline our approach and suggest some modifications that we might make if we were to repeat the study.

Based on the views and experiences of respondents, we can say that the NDC's services and resources are valued by our users and have had positive impacts on their work. These impacts have been wide-ranging and have brought about affective, knowledge-based, behavioural, and competence-based change in practice. The study provides the NDC with a significant body of evidence on which to base plans for the development of resources and services over the next few years.

'Lead us not into temptation': adolescence and alcohol policy in Europe

Hope A
Alcohol and Alcoholism, 2014, 49(2): 126–127.
www.drugsandalcohol.ie/21446

Although the World Health Organization and the European Community recognize harm to children and young people due to alcohol – whether their own or someone else's drinking, effective policies to reduce harm are not widely followed. The alcohol beverage industry's drive to use social networking systems blurs the line between user-generated and industry marketing materials, such that young people are more frequently and at a younger age, potentially exposed to the promotion of alcoholic drinks. This contravenes recommendations arising out of the emerging scientific literature that delaying the onset of drinking and reducing the prevalence of heavy session drinking are likely to promote a healthier next generation.

Alcohol and youth mental health – the evidence base

Fitzgerald A and Dooley B
Psychiatry Professional, 2013, 2(1): 6–8.
www.drugsandalcohol.ie/21265

The My World Survey–Second Level (MWS–SL) assessed alcohol-related behaviours in 6,085 adolescents. Findings demonstrated a significant shift in the frequency, binge drinking and volume of alcohol consumed across the school year. Alcohol use in the Senior Cycle was a particular concern, with 35% outside the low risk category for alcohol behaviour. The MWS-SL found a strong relationship between alcohol use and mental health distress. Risky alcohol behaviour was associated with family conflict and other negative behaviours.

Adolescent males in secondary school in Ireland: alcohol use and depressed mood

Kerr RA
Irish Journal of Applied Social Studies, 2013, 13(1): Article 3.
www.drugsandalcohol.ie/21266

Per capita alcohol consumption by Irish teenagers has doubled over the past three decades. There has also been a doubling of the suicide rate among young men. This study aimed to measure the correlation between alcohol consumption and negative mood (using the Beck Depression Inventory) in a sample (n = 169) of final-year secondary school male students. A questionnaire was devised to ascertain frequency, type and quantity of alcohol consumed, attitudes towards drinking in general, and to assess overall mood disturbance. These two sets of results were analysed and correlation coefficients calculated. It was found that both alcohol consumption and mood disturbance varied widely throughout the sample and that total alcohol consumption correlated weakly but significantly with overall mood disturbance. However, there was a stronger, more significant correlation between frequency of feeling drunk and mood disturbance, indicating a much greater effect on the teenagers' mood from binge drinking than from consistently drinking the same quantity of alcohol.

A review of drug-facilitated sexual assault evidence: an Irish perspective

McBrierty D, Wilkinson A and Tormey WP
Journal of Forensic and Legal Medicine, 2013, 20(4): 189–197.
www.drugsandalcohol.ie/21237

Drug-facilitated sexual assault (DFSA) is prevalent in Western society. There is a significant degree of confusion regarding the definition and prevalence of DFSA. It is a subject with medical, scientific and legal aspects. These facets are explored in this review through a detailed examination of published data. The legal issues are defined in the context of the Irish judicial system. Several key case-law studies are presented to aid in understanding unresolved difficulties that persist in this complex field of forensics. The aim of this paper is to aid individuals from disparate disciplines to increase their evidence base in the complex and evolving issue of DFSA.

Non-medical use of psychotropic prescription drugs among adolescents in substance use treatment

Apantaku-Olajide T and Smyth BP
Journal of Psychoactive Drugs, 2013, 45(4): 340–346.
www.drugsandalcohol.ie/21192

Little is known about the extent of non-medical use of prescription drugs among European adolescents with substance use disorders. This cross-sectional study examined non-medical use of seven categories of psychotropic prescription drugs (opioid analgesics, ADHD stimulant, sleeping, sedative/anxiolytic, antipsychotic, antidepressant, and anabolic steroid medications) in a clinical sample of

Recent publications *(continued)*

Irish adolescents with substance use disorders. Of the 85 adolescents (aged 13-18 years) invited to participate, 65 adolescents (M = 16.3 years, SD = 1.3) took part (response: 74%). Among respondents, 68% reported lifetime non-medical use of any of the prescription drugs; sedative/anxiolytic (62%) and sleeping medications (43%) were more commonly abused. The most frequently reported motives for abuse were "seeking high or buzz" (79%), "having good time" (63%), and "relief from boredom" (56%). Sharing among friends and street-level drug markets were the most readily available sources. Innovative solutions of control measures and intervention are required to address the abuse of prescription drugs.

Impact of new UK paracetamol overdose guidelines on patients presenting to the emergency department

Nfila G, Lee S and Binchy J
Irish Medical Journal, 2014, 107(2): 47.
www.drugsandalcohol.ie/21455

Paracetamol is involved in a large proportion of overdoses that present to the Emergency Department (ED), either as lone or mixed overdoses. Non-treatment of toxic levels can lead to fulminant liver failure. This study is to determine the impact the new UK treatment guidelines[1] will have on patients presenting with paracetamol overdose. A retrospective review was performed on all patients who had paracetamol levels done in the ED between September 2011 and August 2012.

A total of 523 patients were identified, 95(18%) of whom had detectable paracetamol levels. 74 patients from the 95 were evaluated. 18(24%) patients were treated with N-acetylcysteine as per the then paracetamol overdose guidelines. Using the new guidelines would have resulted in 3 more patients being admitted. Our study shows that most patients who present following paracetamol overdose do not require treatment with N-acetylcysteine and suggests that the introduction of the new UK treatment guidelines is likely to result in only a small increase in the number of patients requiring treatment.

Health-related quality of life of HIV-infected intravenous drug users

Surah S, Adams R, Townsend L, Reynolds I *et al.*
International Journal of STD & AIDS, 2013, 24(11): 867–874.
www.drugsandalcohol.ie/21444

To investigate health-related quality of life in HIV-infected intravenous drug users registered but not engaged in HIV outpatient care we conducted a cross-sectional study to examine health-related quality of life of HIV-infected intravenous drug users registered for care at an inner city HIV unit. EQ-5D, SF-36, SF-6D, mood disorder, clinical and substance misuse data were collected. Mean scores and preference derived utility scores were calculated.

Statistical relationships between health-related quality of life and other variables were explored using univariate and multivariate analysis. Fifty-five patients were recruited, 64% were males. The mean anxiety value was 11.44 (anxious) and mean depression score was 9.3 (borderline depressed). The mean EQ-5D utility was 0.45 (95% CI 0.35, 0.55) and mean SF-6D utility was 0.52 (95% CI 0.48, 0.55). There was no statistical relationship between HIV indices, substance misuse and EQ-5D and SF-6D utility. Anxiety and depression were significantly correlated with EQ-5D and SF-6D utility values on univariate and multivariate analysis. Health-related quality of life was reduced in this HIV-infected intravenous drug user population. Whilst hepatitis C co-infection and substance misuse did not affect health-related quality of life, anxiety and depression had a significant impact on it.

Emergence of opiate-induced neonatal abstinence syndrome

Healy D, English F, Daniels A and Ryan CA
Irish Medical Journal, 2014, 107(2): 46.
www.drugsandalcohol.ie/21454

Neonatal abstinence syndrome (NAS) is the clinical picture of infants withdrawing from in-utero substance exposure. The incidence of NAS rose in Dublin maternity hospitals in the 1970s and 1980s in parallel with increasing opiate abuse in that city. The purpose of this study was to determine if a similar pattern was emerging in Cork University Maternity Hospital. Data from the Erinville Hospital (2000-2007) and CUMH (2008-2011) were compared. Sixteen cases of NAS were identified, two at Erinville Hosptial and 14 at CUMH. Five of the 16 mothers were using heroin, while ten were on methadone maintenance. All were multi-drug abusers. Newborns requiring pharmacotherapy for NAS (5/16) had prolonged hospitalisations compared to those requiring supportive care. NAS in Cork is increasing. Primary, secondary and tertiary preventative measures are warranted to prevent further escalation.

Open drug scenes and drug-related public nuisance: a visual rapid assessment research study in Dublin, Ireland

Van Hout MC and Bingham T
Journal of Ethnicity in Substance Abuse, 2013, 12(2): 154-178.
www.drugsandalcohol.ie/21345

The research was undertaken at a time of increasing public concerns for drug- and alcohol-related public nuisance in the city centre of Dublin, Ireland. Rapid Assessment Research was conducted involving qualitative interviewing with drug service users; business, transport, community, voluntary, and statutory stakeholders (n = 61); and an environmental mapping exercise.

The interplay between homelessness, loitering, an influx of drug users via city metro systems, transient open drug scenes, street drinking, drug injecting, intimidation, knife crime, and prescribed medication abuse was evident. Potential strategies to address drug and alcohol related public nuisance are advised to include the relocation of treatment services, targeted harm reduction initiatives, urban regeneration, improved community rehabilitation pathways, and heightened policing intensity.

Towards a Framework for implementing evidence based alcohol interventions

Armstrong R and Barry J
Irish Medical Journal, 2014, 107(2).
www.drugsandalcohol.ie/21433

This study tested the feasibility of screening and brief intervention (SBI) within four emergency departments. A total of 944 patients were screened for hazardous and harmful alcohol use. The results showed that there was good co-operation from the public, with 888 (94%) people agreeing to be screened. The screening tool detected that 460 (49%) of those needed no intervention, 345 (36%) needed brief advice and 83 (9%) required referral to specialist services. This showed the value of the screening but also helped to reassure staff that people were happy to take part.

Upcoming events

(Compiled by Joan Moore – jmoore@hrb.ie)

April

29–30 April 2014
Recovery from Addiction: Bridging the Gap between Policy and Practice
Venue: University of Chester, UK
Organised by/Contact: CSARS Group
Email: roberts.t@chester.ac.uk
Web: http://shopfront.chester.ac.uk/index.php?main_page=product_info&products_id=298

Information: Recovery has become more central to the addictions treatment policy agenda than ever before, but the nature of recovery and means of achieving it are subject to vigorous debate. This event will provide a forum for policy makers, commissioners and practitioners, together with representatives from mutual aid groups and the wider recovery movement. It aims to raise awareness of the diversity of the recovery landscape and to build consensus towards more cohesive policy implementation. It will be useful to substance-misuse workers, health and social care professionals, probation & criminal justice workers, counsellors, psychotherapists and psychiatrists, members of mutual-aid groups and others involved with, affected by, or in recovery. **Dr David Best**, Associate Professor, Monash University, & Turning Point Alcohol and Drug Centre, Australia, will be among the keynote speakers.

May

7–9 May 2014
2nd European Harm Reduction Conference
Venue: Basel, Switzerland
Organised by/Contact: European Harm Reduction Network (EuroHRN)
Email: harmreduction@infodrog.ch
Web: www.harmreduction.ch/en/

Information: The conference aims to offer an ideal platform to discuss the present and future of harm reduction and to promote the further development of the concept in different European countries. The most recent developments in harm reduction practice will be explored at the meeting as well as international models of regulating drugs. Registration for the conference is now open.

15–16 May 2014
3rd international conference on novel psychoactive substances
NPS and behavioural addiction
Venue: Rome
Organised by/Contact: EMCDDA and others
Web: www.novelpsychoactivesubstances.org

Information: The event will be organised by: the University of Hertfordshire; the EMCDDA; the University of Chieti-Pescara; 'Sapienza' University of Rome; and 'Guglielmo Marconi' University. The event is sponsored by the Società italiana di psichiatria.

In the past 25 years a variety of novel (or 'new) psychoactive drugs (NPS) have become available, and they are often misrepresented as 'safer' and 'legal" alternatives to illicit drugs. NPS are often sold via the Internet, where information on their effects is minimal or inaccurate. This conference will offer participants an opportunity to share evidence-based information on NPS and improve understanding of prevention, treatment and management approaches in this area.

21–23 May 2014
International Society for the Study of Drug Policy Eighth Annual Conference
Venue: Rome
Organised by/Contact: ISSDP
Email: cibb@uniroma2.it
Web: www.cibb.uniroma2.it/index.php/ct-menu-item-28?id=71

Information: The 2014 ISSDP conference will be held in Rome, Italy, where state-of-the-art monitoring and epidemiology, along with innovative treatment, law enforcement and prevention approaches are all on display. The conference will provide a rich programme of world-class drug policy research from across the globe.

22–23 May 2014
European Working Group on Drugs Oriented Research (EWODOR)
15th Symposium: Gender and Diversity
Venue: Trinity College Dublin
Organised by/Contact: EWODOR/Coolmine Therapeutic Community
Email: eoinc@coolminetc.ie
Web: www.coolmine.ie/ewodor

Information: EWODOR is a network of addiction researchers closely aligned to the European Federation of Therapeutic Communities (EFTC). At this symposium you will learn, be inspired by discussion and debates, and be motivated in your day-to-day work through new research, skills and networking with colleagues.

***Drugnet Ireland* is published by:**

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